Impact of SEA 493 Provisions on Indiana's Aged and Disabled Waiver

Prepared for:

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EXECUTIVE SUMMARY

A. Introduction

The Indiana Division of Disabilities, Aging, and Rehabilitative Services (DDARS) and the Office of Medicaid Policy and Planning (OMPP), sister agencies housed in the Indiana Family and Social Services Administration (FSSA), contracted with The Lewin Group to study the impact of Senate Enrolled Act (SEA) 493. This important measure makes significant changes in the State's long term care (LTC) programs for individuals of advanced age and persons with disabilities, and this study focuses on the impact of changes to the State's Section 1915(c) Aged and Disabled (A&D) Medicaid Home and Community-Based Services (HCBS) waiver. The State General Fund-only Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) program is considered as well, as it relates to those changes in the A&D waiver.

FSSA asked Lewin to study the impact of specific SEA 493 provisions on the A&D waiver: a) increasing the income limit for eligibility; and b) adding new service "slots" under the A&D waiver at the increased income level. Lewin also examined whether the costs associated with these expansions could be offset by transitioning individuals out of nursing homes and into the A&D waiver, which on a per person basis is less costly than a nursing home, and diverting individuals at risk of nursing home placement into HCBS settings. Furthermore, Lewin studied the impact of eliminating waiver participants' cost sharing responsibilities under the A&D waiver. And, finally, Lewin estimated costs associated with increased administrative capacity to ensure the health, safety, and welfare of participating individuals as well as appropriate stewardship.

Lewin found that:

- *Expanding waiver eligibility and increasing the number of waiver "slots," as required in SEA 493, would constitute a significant expansion that would provide valuable services to several thousand additional Indiana residents. This coverage, however, entails notably higher net Medicaid costs despite small offsets from nursing home diversion and transition efforts;*

- *Elimination of consumer cost sharing responsibilities under the waiver (i.e., spend-down) would further increase state costs; and*

- *FSSA and local waiver administration sites, the Area Agencies on Aging (AAA), would need to enhance critical administrative infrastructure to support the waiver program such as case management services, quality assurance and improvement, hearings and appeals capacity, provider recruitment and retention, as well as technical support to the AAAs. These efforts*

Things to Know about SEA 493 Implementation

Expectation of Indiana LTC System – *SEA 493 is budget neutral and will be self-funding.*

Reality about Indiana LTC System – *To move to a uniform eligibility level between nursing home and the A&D waiver of 300% of SSI constitutes a significant expansion in coverage.*

- *Covering more than 5,000 additional persons*
- *Increased costs would be considerable (e.g., in fiscal year (FY) 2007, SEA 493 would cost $150 million in total, $63 million in state funds)*

would entail increased costs in the short term and significantly greater costs in the long term as A&D waiver participation continues to grow.

In addition to enrollment and cost estimates, Lewin also provides *incremental* options for achieving implementation of SEA 493 which would allow the State time to develop needed community capacity and infrastructure. The report also offers several policy and administrative recommendations that also would facilitate SEA 493 implementation.

B. Background

Indiana's LTC population is a mosaic of different age groups, functional capabilities, and health status, which requires a complex array of services over an extended period of time. These services and supports address various social, custodial, and medical needs. The vast majority of LTC in the United States is provided by family and friends on an informal basis. In Indiana, as elsewhere, the remaining small portion of LTC is provided by a patchwork system of formal services and programs. Paid, formal services in Indiana are covered by state-only dollars through CHOICE and by combined state and federal dollars through the Medicaid program. Each community (i.e., state and local) has, over time, developed its own combination of service resources, funding streams, and organizational structures. This is especially true in Indiana where a local network of single points of entry, the AAAs, serve as the intake and case management centers.

Things to Know about SEA 493 Implementation

Expectation of Indiana LTC System – *If other states have succeeded in rebalancing long term care systems, so can Indiana*.

Reality about Indiana LTC System – *All states have different starting points (i.e., nursing home bed capacity, Medicaid income thresholds, HCBS systems capacity, and number of years operating waivers), thus comparisons must be made carefully to accurately support policymaking.*

State governments offer many models for delivering care and expanding the availability of LTC services for persons of all ages. Also, states are continually designing innovative and fiscally responsible ways to enable more persons with disabilities and individuals of advanced age to receive a continuum of services in their communities and homes rather than in nursing homes. These efforts have proven to be among the most challenging initiatives in the history of the U.S. health and human services system as demand for LTC services has grown and health care costs have skyrocketed.

Indiana, while lagging behind in some areas of LTC systems evolution, has been an innovator in others. The Hoosier State was slow to take advantage of the Section 1915(c) waiver authority, implementing its first HCBS waiver in 1989 while most states began operations in the early 1980s. In recent years, however, the Indiana long term care community has made significant strides in shifting from institutional services to HCBS. Since state fiscal year (SFY) 2000, spending on nursing homes has decreased by 14 percent while spending on the state's eight HCBS waivers has increased by 17 percent. Indiana also operates a nationally lauded nursing home diversion and transition program and has sought and received several federal grants aimed at

Things to Know about SEA 493 Implementation

Expectation of Indiana LTC System – *Indiana has made no progress shifting from nursing home use to HCBS*.

Reality about Indiana LTC System – *The nursing home share of the total Indiana long term care budget has decreased by 14 percent since 2000, while HCBS expenditures have grown by 17 percent due to transitions into HCBS.*

improving long term care service outcomes for consumers and their families. Finally, FSSA is in the process of making a series of waiver operational improvements including refinement of the new consolidated Waiver Services Unit, development of several new quality assurance and improvement strategies for the A&D waiver, enhanced consistency among AAA regions, and acquisition of new information technology tools that will improve case management services. All of these efforts will put Indiana in a better position to implement SEA 493.

C. Principal Findings and Options for Implementation

Indiana policymakers will decide how, when, and in what manner the A&D waiver is modified. Below, Lewin provides estimates of how the SEA 493 eligibility changes impact the waiver and also offers options for incremental implementation of the measure that, in the face of an estimated $700 million state budget shortfall, may be more acceptable both to taxpayers and State Legislators responsible for budgeting and appropriation of state funds. Based on experiences with other states and knowledge of federal rules and a review of the Indiana LTC system, Lewin also offers policy and programmatic findings and recommendations that would foster HCBS expansion and further reduce use of nursing home services.

Things to Know about SEA 493 Implementation

Expectation of Indiana LTC System – *Three people can be served in HCBS settings for the cost of one person in a nursing home.*

Reality about Indiana LTC System – *Annual claims costs for low-acuity nursing home patients average approximately $36,000, versus $23,000 for waiver enrollees. Thus, for every two people transitioned from a nursing home to the waiver (two people at $13,000 in savings apiece), approximately one additional person not currently served by the waiver could be added at no additional net cost.*

Our estimates modeled the costs of two simultaneous policy changes – removing the waiting list barrier to enrollment and eliminating spend-down requirements such that Waiver coverage entails no costs for persons with incomes up to 300 percent of SSI. These impacts are summarized below:

- Removing the waiting list restriction and permitting enrollment without spend-down for persons with incomes up to 300 percent of SSI would, over time, result in more than a 250 percent increase in Waiver enrollment. The SEA 493 provisions would constitute a coverage expansion that would be of significant benefit to several thousand Indiana residents, but which also creates corresponding Medicaid cost increases.

Things to Know about SEA 493 Implementation

Expectation of Indiana LTC System – *It is feasible to move at least 20,000 people out of nursing homes.*

Reality about Indiana LTC System – *Indiana has made a significant effort to transition people from nursing homes and has found transition to be challenging. Success in thousands of transitions is not realistic in the near term based on national nursing transition experiences.*

- The added cost of a new waiver enrollee is estimated to be approximately $23,000 in FY2005, versus $36,000 for institutionalized persons. Waiver enrollees who are new to the Medicaid program thus create a cost of $23,000 per person in that year; Waiver enrollees who would otherwise be Medicaid nursing home residents in that year create a *savings* of $13,000.

- The net additional costs (Federal and State funds combined) associated with these design changes total more than $150 million per year from FY2007 forward, reaching $258 million in FY2015. (The State share of these added costs is projected to be 38 percent of the total cost.) These costs include the offsetting savings that will occur through nursing home transitions, delays and diversions.

Things to Know about SEA 493 Implementation

Expectation of Indiana LTC System – *The population not receiving – but in need of – waiver services is primarily composed of persons on the waiting list.*

Reality about Indiana LTC System – *The majority of people who would likely enroll in the waiver after the policy changes actually are individuals who are not on the waiting list.*

- If the SEA 493 provisions were restricted to persons up to 150 percent of SSI (instead of 300 percent of SSI), the enrollment and cost impacts would be only 30 percent of those quantified above.

1. HCBS Expansion Implications for Administrative Infrastructure

A 2003 federal report identified major problems in state A&D waiver strategies intended to ensure the health, safety and welfare of persons of advanced age and individuals with physical disabilities enrolled in such programs. Common problems included: 1) failure to provide authorized or necessary services; 2) inadequate assessment or documentation of care needs; and 3) inadequate case management.[1] These elements constitute some of the components of administrative infrastructure needed to effectively and efficiently operate the waiver. Poorly developed or under-funded administrative systems lead to health and safety issues, consumer dissatisfaction with services and/or providers, and inefficient waiver management which has implications for service capacity.

Things to Know about SEA 493 Implementation

Expectation of Indiana LTC System – Medicaid has the opportunity to divert everyone before they enter a nursing home.

Reality about Indiana LTC System – *Roughly half of nursing home residents are not enrolled in Medicaid until they become nursing home residents.*

Things to Know about SEA 493 Implementation

Expectation of Indiana LTC System – *The current community-based capacity (i.e., providers, quality assurance, and administrative systems) would be able to absorb substantial short-term growth.*

Reality about Indiana LTC System – *States that have experienced HCBS expansion approximating SEA 493 growth have taken many years to develop the necessary base of qualified providers, essential quality assurance systems that foster safety and well-being, and administrative oversight.*

Through interviews with state agency staff and questionnaires sent to A&D waiver providers and AAAs, Lewin found notable concerns from all parties about the current administrative capacity of the waiver to support a significant number of new waiver participants in a safe and effective manner. Themes included the need for more case managers, better quality assurance strategies, enhanced consistency across AAA regions, more qualified

[1] U.S. General Accounting Office, "Long-Term Care: Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should Be Strengthened," GAO-03-576, June 2003.

providers, and better information tools to monitor program performance, improve programmatic stewardship and responsiveness to consumer needs.

Based on these findings, Lewin estimated costs related to waiver growth both in the short term (i.e., 2005 through 2007) and the long term (i.e., 2010 and forward), when the waiver would grow significantly. In the short term, Lewin primarily estimated increased costs in terms of personnel. However, due to the number of waiver oversight and administration components currently undergoing improvements and organizational changes (i.e., development of the Waiver Services Unit, enhancement of the quality strategy, changes in AAA responsibilities and performance monitoring, and new case management/client tracking software), Lewin focused the out year administrative estimates on automation and information technology that would likely be needed to support a program of the scale we estimate the A&D waiver program would approach. ***Table ES-1,*** below, provides an overview of those **administrative costs**.

Table ES-1. Short Term and Long Term Administrative Costs

Cost Area	2005 Estimate	Potential Out Year Estimate
Eligibility and Case Management	$772,000	$6.49 - $6.6 million
Provider Capacity	$79,000	$3.06 million
Quality Assurance	$140,000	$1 million
Management and Administrative Support	$108,000	TBD
Totals	**$1.10 million**	**$10.6 - $10.7 million**

Many of these costs are eligible for federal Medicaid matching funds either at Medicaid service matching rates, case management, or at the Medicaid administrative matching rates including eligibility determination, certain quality assurance functions, and information systems that directly relate to waiver functions.

2. Recommendations for HCBS Expansion

The rapid pace of change in both the Medicaid and LTC environments and the complexity of the issues to be addressed dictates that any effort to create and sustain change within a publicly administered LTC system must be guided by a carefully developed strategic plan. Indiana should focus on four domains in an operational plan aimed at SEA 493 implementation:

Things to Know about SEA 493 Implementation

Expectation of Indiana LTC System – *Additional slots are needed to support nursing home transitions.*

Reality about Indiana LTC System – *Indiana already has committed staff and resources to assisting any interested individual who qualifies to move from a nursing home to HCBS; a waiver slot is available to any interested party.*

- Goals and objectives that would yield easy-to-find and responsive services that facilitate ***access*** to the waiver and related HCBS services;
- Effective and careful plans ensuring ***cost effective*** services that would increase the potential number of people served by the waiver with an emphasis on consumer control over individual service dollars;
- Plans to develop, regularly review, and improve ***quality*** assurance and improvement systems; and
- Collaborative stakeholder strategies to design and build needed waiver administrative ***infrastructure***.

An action-oriented strategic planning process would be led by individuals empowered to make decisions impacting policy and resources and would include *all* needed state agency stakeholders. Such a body also should have an avenue for meaningful input from consumers and families as well as the organizations that represent them, provider organizations including both institutional providers and HCBS providers, and legislators responsible for health and human services issues and budgeting. Either within a strategic planning initiative or without, Lewin recommends that Indiana investigate the following findings and recommendations as it approaches an HCBS expansion (see ***Table ES-2***, below).

Table ES-2. Lewin Findings and Recommendations

Finding	Recommendations
Acute care providers remain a significant source of nursing home referrals	• *Develop regional materials and educational events for primary care physicians to educate them about HCBS options* • *Enhance private hospital and long term care systems communication by studying feasibility of licensing hospitals as Targeted Care Management providers who could deliver diversion and transition services* • *Explore partnering options with Aging and Disability Resource Centers (ADRC) project of the U.S. Administration on Aging* • *Explore integrated long term care and acute care services under managed care arrangements (e.g., Arizona, Wisconsin, and Michigan)*
Indiana family caregivers report difficulties accessing information on LTC choices	• *Develop information dosing (i.e., information according to need at a given time) strategies including partnering with the Indiana Society for Human Resource Managers, faith-based organizations and churches that provide family assistance, and other agencies and associations* • *Explore leveraging of federal grant resources awarded to improve service access*
Consumer direction has been leveraged only to a limited degree	• *Building on work already conducted under an existing federal grant, establish a committee of consumers and families that would craft a framework for enhanced consumer direction across long term care programs possibly by establishing an array of guiding principles applicable to HCBS waiver renewals, state Medicaid plan amendments, etc.* • *FSSA should accelerate studies of alternative models of case management/support coordination such as support brokerage models and fiscal intermediaries*

Finding	Recommendations
Static reimbursement systems yield inefficiencies and limit consumer control	• *Study business models for CHOICE/A&D waiver providers to gain a better understanding of needed revenue to ensure quality services* • *Explore the development of an assessment tool that would produce service need ratings in tiers; reimbursement tiers would be associated tier or level of support need* • *Explore individualized budgeting options*
Indiana is currently centralizing many current AAA functions	• *Increase staff responsible for AAA oversight and support in the Waiver Services Unit and/or DDARS* • *Consider studying the implications of competitive bidding for SEP contracts to encourage more efficient and effective practices (e.g., Colorado)*
Independent Case Managers do not consistently follow FSSA procedures	• *Work with AAAs and other agencies and organizations to advance plans to increase oversight and performance standards*
While steps have been taken to increase waiver provider numbers, a shortage is likely to emerge	• *Assign provider "Network Developer" responsibilities to an OMPP/DDARS staff to oversee and support AAA contracting efforts aimed at increasing the number and capacity of HCBS providers (e.g., Wisconsin)* • *Consider economies of scale payment to providers and AAAs in very rural or urban areas where recruitment and retention is especially difficult*
Indiana currently manages the waiver budget using a slot allocation system	• *Related to recommendations for tiered reimbursement or individualized budgeting, opt to manage the waiver appropriation following a more individualized service planning model not using a slot model*
ICES and other key social service information systems do not communicate effectively	• *As part of the SEA Strategic Implementation Plan, consider strategies to significantly enhance LTC program reporting systems*
SEA 493 directs FSSA to explore steps to enhance consumer direction and control	• *Consider adding services to the waiver that facilitate consumer control and direction such as Consumer Education and Family Support Services* • *Consider converting the waiver at renewal to an Independence Plus waiver*
Indiana's practice of budgeting separately for institutional and HCBS services limits its capacity to shift dollars between settings	• *Partnering with key stakeholders, enhance the current blended long term care budget model (i.e., global long term care budgeting) to better facilitate money following the person and provide DDARS and OMPP staff more fiscal control and increase their ability to respond to consumer needs*

Indiana faces complex choices and decisions in light of SEA 493. Absent budgetary constraints (i.e., the pending $700 million shortfall) and concerns about adequate infrastructure to support waiver expansion, SEA 493 or related HCBS expansion is a reasonable policy goal. The question for Indiana is whether such a level of fiscal effort is a priority for taxpayers and their representatives in the State Legislature and, if so, how to achieve such changes in a safe and sustainable manner that addresses cost issues, provides a feasible timeframe, and identifies needed resources.

Things to Know about SEA 493 Implementation

Expectation of Indiana LTC System – *Indiana cannot afford not to completely implement SEA 493.*

Reality about Indiana LTC System – *States that have significantly expanded HCBS continue to experience significant growth in the total long term care budget, just at a slower rate.*

I. INTRODUCTION

The provision of long term care (LTC) services[2] required by individuals of all ages with physical or mental disabilities that hinder their ability to perform "activities of daily living" (ADLs) and "instrumental ADLs" (IADLS) has become an increasingly prevalent topic in the state health policy arena. In recent years, numerous factors have driven the emergence of LTC as an important issue to policymakers, service providers, and consumers in all states. Advances in medical technology and treatment have enabled those with disabilities to live longer, more independent lives. The aging of the population is resulting in greater demand for services as the over-65 population grows significantly. State Medicaid LTC programs are bearing a significant financial responsibility for supporting the health and LTC needs of persons of advanced age and persons with disabilities. Additionally, a growing consumer choice movement in the health and social services fields and growing efforts to develop programs for individuals with cross-disability needs have added to the magnitude of the LTC challenge. No one factor is viewed as the major impetus for reform. In fact, many components have conjoined in propelling LTC to become a particularly important issue at the beginning of the 21st century.

Local community-based programs, providers, and numerous state agencies – all with their often-diverging definitions of functional and financial eligibility criteria for service delivery and separate strategies for monitoring programs – interact daily with individuals needing LTC throughout the United States. States are under increasing pressure to develop LTC systems and mechanisms that broker services in a coordinated fashion to facilitate navigation by consumers, both old and young, across programs, agencies, funding streams, and a continuum of service needs. Additionally, fostering community-based alternatives to institutional services, as well as strategically developing supporting infrastructures, are growing issues in deliberations about LTC in many states. Largely catalyzed by demographic trends, consumer preferences, sizeable federal grants, the Americans with Disabilities Act (ADA) (especially as interpreted by the Supreme Court in the 1999 ***Olmstead*** Decision), and changes in federal Medicaid laws, a shift in focus from institutional care to home and community-based services (HCBS) is rapidly occurring throughout the United States.

A. Purpose

In 2002, the Indiana General Assembly passed Senate Enrolled Act 493 (SEA 493), requiring certain alterations to the State's Aged and Disabled (A&D) Medicaid Waiver, which provides services in home and community-based settings to those who qualify (see ***Section IV*** for a discussion of Medicaid-financed HCBS programs). SEA 493 was the impetus for this project.

While there are many elements in SEA 493, Lewin was asked to model only specific provisions impacting the A&D waiver including: a) increasing the financial eligibility income standard from 100 percent of the Supplemental Security Income (SSI) standard to 300 percent of the SSI

[2] For the purposes of this study, The Lewin Group adopted the following Institute of Medicine definition: "Long-term care is a diverse array of services provided over a sustained period of time to people of all ages with chronic conditions and functional limitations. The population's needs range from minimal personal assistance with basic activities of everyday life to virtually total care. Those needs are met in a variety of care settings, such as nursing homes, residential care facilities, or people's homes."

standard payment amount. In addition, FSSA asked Lewin to analyze whether transitioning certain numbers of individuals out of nursing homes would offset any new costs associated with increasing the countable income test for A&D waiver eligibility.

Lewin also modeled the impact of increasing the Post Eligibility Treatment of Income (spend-down) calculation from the State claiming any amount over 100 percent of SSI as cost of care for each waiver participant to claiming amounts over 300 percent of SSI for each waiver participant. This final change would effectively eliminate the cost of care responsibility for A&D waiver participants. Finally, Lewin estimated the short and long term administrative costs that would be associated with any notable A&D waiver growth.

1. Overview of Measure

SEA 493 includes a variety of provisions in areas such as eligibility, spend-down, waiver slot numbers, covered services, spousal impoverishment, caretaker support, continuum of care, personal individualized care plans, self-directed care options, bed conversions, and funding. Of particular interest to this study are certain requirements related to the A&D HCBS waiver, including eligibility and spend-down, number of slots, spousal impoverishment, and covered services. Provisions assessed in this report are the requirements to amend two eligibility components of the waiver and to seek approval for an additional 20,000 waiver slots. The statute also directs OMPP to amend the A&D Waiver to include any services offered by the CHOICE program, and it must amend Medicaid waivers to include spousal impoverishment protection provisions that are at least at the level of those offered to nursing facility residents. A particularly challenging aspect of the law requires that changes may be implemented only when the funding is available.

Overview of the 300% of Income Rule

- Allows eligibility for persons with gross monthly incomes at or below 300 percent of current SSI -- approximately $1,656.
- Allows states to use the option for persons residing in medical institutions. If they do so, states also can extend the 300% of income level to HCBS waiver eligibility.
- Allows states to provide the HCBS waiver to children without regard to their parents' income or assets, and to married individuals without regard to their spouse's income. (*See footnote regarding this requirement on **Table 1,** below).*
- Requires states to impose a spend-down sharing burden (discussed below).
- When the 300% rule is a state-only option for providing Medicaid to higher income persons in medical institutions (i.e., the state does not have a medically needy program), it allows a person to achieve eligibility by diverting excess income into a Miller Trust. Indiana offers eligibility options other than the 300% special income rule and does not provide Miller Trusts.

Many of the changes required by SEA 493 already had taken place prior to the enactment of the law. For example, waiver services already were based on individualized plans of care, money already was allowed to follow the individual from a facility into the community, waiver services already mirrored CHOICE services, spouses' assets already were protected, and an additional 20,000 waiver slots already had been requested.

See ***Table 1***, below, for more detail on certain provisions of the measure that impact the A&D waiver, steps the State has taken to address each provision, and how Lewin addressed each element.

Table 1. Overview of Senate Enrolled Act 493 Impacting the Aged and Disabled Waiver

Measure Provision	What does this provision do?	What have been OMPP steps to date?	How was this considered in the Lewin study?
Increase countable income from 100 percent of SSI to 300 percent of SSI.[3]	Before, only individuals with incomes at or below 100 percent of SSI, or approximately $552, could participate. Changes the waiver financial eligibility rules to allow people with gross incomes at or below 300 percent of SSI (approximately $1,656) to participate. These individuals are currently enrolled but must spend down.	OMPP amended the waiver making this change at CMS' direction when the spousal impoverishment changes were made in November 2002.	Lewin modeled how many people could move into the waiver under the new income standard from nursing homes, CHOICE, and people who are not currently using either. For detail see Section V.
Add 20,000 slots to the A&D waiver assuming that complementary reductions in nursing home utilization would pay for new waiver expenses.	Currently, the A&D waiver is capped at 6,000 participants based on the current waiver allocation made by the State Legislature. Under SEA 493, the waiver would serve up to 20,000 people assuming revenue could be generated from nursing home transition savings.	OMPP asked Lewin to study this hypothesis. Also, OMPP has submitted a 20,000 slot request to CMS.	Lewin modeled the impact of expanding the waiver to accommodate this number of individuals and examined the potential offsets from nursing home transition. This modeling may be found in Section V.
Amend A&D waiver to include spousal impoverishment rules associated with nursing homes.	Changes the waiver to extend nursing home and Assisted Living waiver spousal impoverishment protections to the A&D Waiver. The new limits range from $17,856 to $89,280.	OMPP amended the waiver making this change in November 2002.	Assessment completed prior to and separately from Lewin study.
Amend A&D waiver to include all services that CHOICE offers.	The waiver was amended to include CHOICE services previously not included.	DDARS added these services to the waiver in 2002.	Assessment completed prior to and separately from Lewin study.

[3] The waiver countable income test was increased to 300 percent as part of the spousal impoverishment changes. (Personal communication with FSSA.)

2. SEA 493 Cost Estimates

a. State Legislature Cost Estimates

Regarding SEA 493 A&D waiver provisions, the legislative Office of Fiscal and Management Analysis prepared its own fiscal note. The estimate indicates the total maximum cost of amending the A&D waiver to increase the income level to *300 percent of the SSI standard payment* would be $3.2 million in state and federal funds in state fiscal year 2003 dollars, or $1.2 million in state-only funds in the A&D waiver. The fiscal note assumes the cost is related to the elimination of the *spend-down requirement* (i.e., PETI, see text box at left) for current waiver individuals and assumes OMPP control of funded waiver slots and growth in the waiting list to provide savings. This term should not be confused with the state's broader spend-down program it offers as part of its Section 209(b) aged, blind and disabled eligibility structure.

Overview of Post-Eligibility Treatment of Income (PETI)

- Use of the Special Income Rule for HCBS (i.e., 300% or lower) requires states to impose a PETI (i.e., called "**spend-down"** in Indiana) sharing burden.
- Requires persons who become eligible for Medicaid under the Special Income Rule to pay a share of their income toward the cost of their care. In Indiana, waiver participants and nursing home residents send these payments to local Medicaid eligibility offices operated by the Division of Families and Children (DFC).
- State waiver programs have considerable flexibility in setting waiver participant cost of care contribution requirements. Some states require little or no cost sharing while others have substantial requirements.
- A cost of care calculation is made by subtracting from total income certain amounts that are protected for the individual's personal use (i.e., the maintenance allowance); In Indiana, this protected amount is currently up to 100% of SSI. The remaining income is the individual's cost of care requirement.
- The Medicaid program reduces the amount it pays for Medicaid services by the amount the individual is expected to pay.
- Cost of care requirements can provide substantial revenue for HCBS waiver programs. Some states, such as Oregon, considered eliminating cost of care requirements but the loss of revenue to the waiver proved substantial.

The estimate goes on to assume that savings also may be achieved through an additional 1,000 HCBS diversion slots, to allow individuals who are discharged from a hospital to recuperate in their homes rather than in nursing facilities; diversion from nursing home placement at this decision point is considered a critical step in reducing facility utilization (for more information see Section V, below). These nursing home diversions were assumed to absorb any new costs related to A&D waiver growth.

The *spousal impoverishment protection* provision in the act would have a minor administrative impact. This impact would be absorbed into the current DDARS resources if the number of funded waiver slots is controlled. Again, this provision would serve to increase the number of individuals eligible for Medicaid waiver services and may increase the waiting list, if there are no slots available. Finally, the act requires FSSA to offer *self-directed care* under the Medicaid waiver and in CHOICE before July 1, 2004. This alternative would be fiscally neutral.

b. *Lewin Cost Estimates*

The SEA 493 waiver modifications, specifically increasing the income level and the addition of waiver slots, will lead to increased demand for and utilization of HCBS services primarily through the so-called "woodwork effect" (see *Section IV*). Under this scenario, people who would not have sought institutional services now will seek access to HCBS; this will be especially true now that there is no consumer cost of care requirement (see text below on spend-down).[4] Increased waiver enrollment and increased service utilization will result in significant new costs to the State if complementary changes are not made to nursing home services that will reduce usage levels at a ratio that will offset the increased HCBS costs.

The Lewin Group modeled the provisions of SEA 493 in increments of 50 percent of SSI. Presented in ***Table* 2**, below, are the ranges of possible costs. For more detail see Section V.

Table 2. Comparison of Cost Estimates

Provision of SEA 493	State Legislature Cost Estimate (state/federal)	Lewin Cost Estimate/Observations (state/federal)		
		2005	2010	2015
Increase countable income to 300 percent of SSI	No dollar figure; assumes nursing transition and diversion will cover cost of people new to waiver on a one-for-one basis.	$47 Million	$213 Million	$300 Million
Eliminate Cost of Care or "Spend-Down" Requirement	$3.2 Million/Year	$4.6 Million*	$5.5 Million*	$6.6 Million*
Increase Waiver Slots	No dollar figure; assumes nursing home transition and diversion will cover cost of people new to waiver on a one-for-one basis.	$24,301 per enrollee	$27,073 per enrollee	$30,209 per enrollee
Offsets from Nursing Home Diversion and Transition	No dollar figure; assumes will cover cost of people new to waiver on a one-for-one basis.	$1,039 per enrollee**	$4,383 per enrollee**	$9,939 per enrollee**
Addition of Self-Directed Care	Cost Neutral	Other states report minor savings from steps such individualized budgets and increased levels of consumer control.		

* These costs are included in – not additional to – the figure in the previous row

** These offsets are included in – and should not be subtracted from – the net per person figures in the previous row.

[4] Alecxih, L., Lutzky, S., Corea, J. The Lewin Group, "Estimated Cost Savings from the Use of Home and Community-Based Alternatives to Nursing Facility Care in Three States," November, 1996.

B. Method

1. Approach

The SEA 493 study was conducted between April and November 2004 and The Lewin Group employed a four-pronged strategy. First, a detailed assessment of current A&D waiver operations relied on multiple telephone interviews with numerous state program administrators having responsibilities for various dimensions of the program. Each interview lasted approximately 1 to 1.5 hours.

Agency-level information was collected on:

- Population served and services offered;
- Factors determining type and level of care provided;
- Referral mechanisms and points of entry for consumers;
- Coordination of care efforts among state and community agencies;
- Provider infrastructure;
- Level of consumer involvement;
- Quality assurance; and
- Overall agency perceptions.

Second, Lewin submitted questionnaires to the local single points of entry into the CHOICE and A&D waiver programs, the Area Agencies on Aging (AAAs), a sample of CHOICE and waiver providers, and advocacy organizations to gather their impressions of the HCBS local capacity to absorb significant waiver growth. Third, Lewin reviewed large amounts of waiver and CHOICE program materials including the Section 1915(c) waiver preprint document, operations manuals, provider guidance transmittals from OMPP and its contractor, EDS, and various national reports and resources on Indiana.

Finally, Lewin performed a series of complex quantitative analyses to estimate waiver enrollment and related costs. To gather the data for this area of work, Lewin requested from FSSA person level data on both A&D waiver participants and CHOICE participants. These data were analyzed in tandem with data from the U.S. Census Bureau to estimate total possible participants as well as any offsets resulting from nursing home transition and diversion.

This complex project was designed to capture the impact of a handful of very specific changes to Indiana's A&D waiver. As a result, caveats about the project's design are:

- **Administrative cost information was obtained primarily from State administrators.** Due to the project's scope, information gathering about administrative cost focused on state program and administrative personnel. Data collection at this level was necessary to understand how individual agencies are structured, how numerous state agencies interact, what the state policy issues are, and where the perceived strengths and weaknesses of the LTC system are from a state management perspective.

- **The Lewin Group was unable to gather information from all AAAs and all A&D waiver providers.** The agencies profiled in this study do not constitute the entire range of CHOICE and A&D providers in Indiana and the AAA response rate to our survey was low. However, based on experiences with other states, the comments from the AAA and providers who did respond are typical of local authorities and HCBS providers and, based on that knowledge, appear to be representative.

- **The study reflects a point-in-time assessment and several of the programs reviewed are currently undergoing changes**. At the time of this study, agency staff were assessing the strengths and limitations of programs under their responsibility and considering the needs of populations that they serve to address quality of care and appropriateness of treatment issues. Several state agencies and divisions also are undergoing or are poised to undergo reorganization.

2. Organization of the Report

The remaining sections of this document provide the following:

- ***Section II*** provides an overview of national LTC trends including financing schemes and service delivery trends. It also offers information on Indiana LTC spending trends.
- ***Section III*** provides a detailed overview of Indiana HCBS.
- ***Section IV*** sets the stage for the Lewin analysis of SEA 493 changes by offering an overview of HCBS expansion considerations that all states should consider.
- ***Section V*** provides the Lewin cost estimates associated with SEA 493 changes pertaining to the A&D waiver as discussed above; our estimates include administrative costs as well as service costs.
- ***Section VI*** provides Lewin's recommendations to Indiana regarding SEA 493 implementation and HCBS expansion in general.
- ***Section VII*** provides concluding remarks and a final overarching recommendation for SEA 493 implementation.

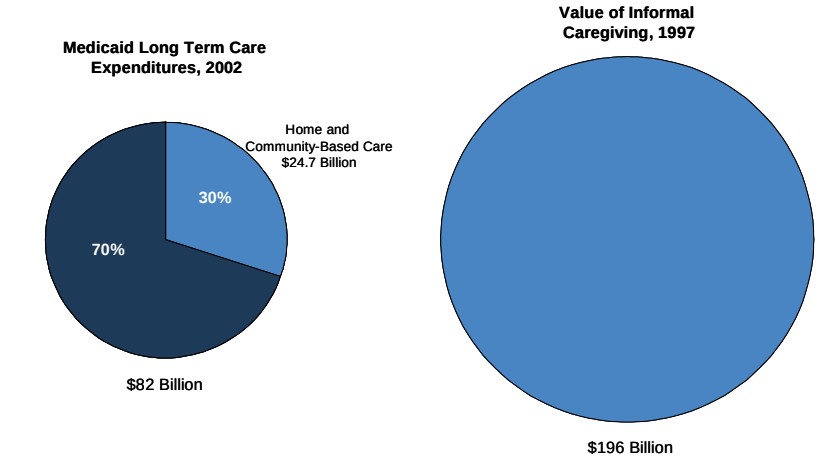
II. LONG TERM CARE OVERVIEW

LTC services include an array of medical and non-medical services and supports for individuals requiring ongoing assistance with activities of daily living, or ADLs, which include eating, dressing, bathing, toileting, etc. Supports and services may include periodic physician visits or physical therapy, assistance with transportation, personal care in the workplace, and even homemaker or chore services. Populations of individuals receiving publicly funded LTC supports and services include persons ages 65 and older and persons with disabilities including physical disabilities, mental illness, sensory disabilities (i.e., blind and/or deaf), traumatic brain injuries, and cognitive disabilities including mental retardation and related developmental disabilities (MR/DD). It is important to note that age and disability are not discreet categories (i.e., someone may be over age 65 and have a disability). Additionally, some people with disabilities have multiple disabilities such as MR/DD, a mental illness or a physical disability and a sensory disability.

The federal and state governments jointly finance Medicaid, and the states administer it within broad federal guidelines for eligibility and benefits. The federal government matches state Medicaid spending with the federal share of Medicaid spending ranging from 50 percent to 77 percent of expenditures depending on state per capita income. In 2002, the federal government financed 57 percent of the $250 billion in total U.S. Medicaid spending; approximately $82 billion of this sum covered Medicaid-financed long term care services.[5]

The vast majority of professional, paid LTC services in the United States are covered by Medicaid. However, the nation's formal LTC service system (i.e., all paid institutional and community-based services) for all persons of advanced age and persons with disabilities of any age provides only a fraction of LTC support and care-giving; the majority of support services are delivered informally by family members or other sources of natural supports. ***Figure 1***, below, provides a graphical depiction of paid versus informal LTC support sources.

Figure 1. Comparison of Long Term Care Costs



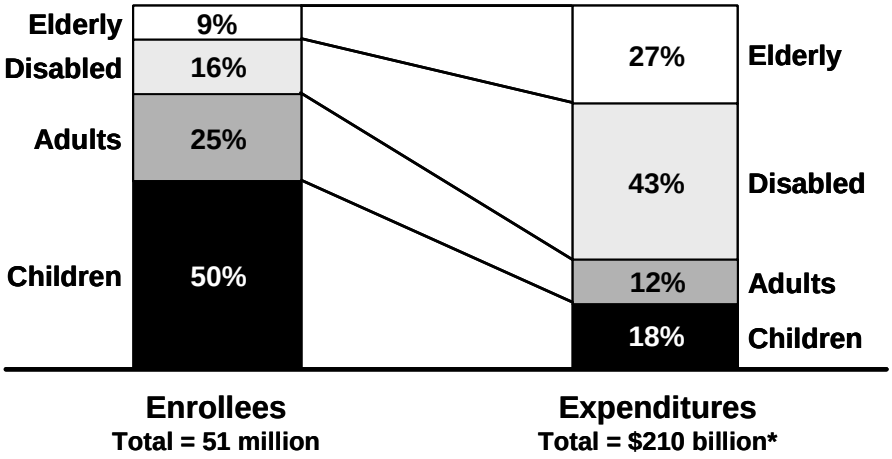
Source: The MEDSTAT Group, Medicaid HCBS Waiver Expenditures, FY 2002

Source: P. Arno, et al., The Economic Value of Informal Caregiving, Health Affairs, Vol. 18, No. 2

[5] The Medicaid Program At a Glance, Kaiser Commission on Medicaid and the Uninsured, January 2004

Nationally and in Indiana, children comprise the bulk of Medicaid enrollment, accounting for 50 percent in Indiana and 66 percent nationally. However, coverage for children's health care services is considerably less costly than coverage for services for persons with disabilities or persons of advanced age. These individuals typically use more costly LTC services and are heavier users of medical benefits such as pharmaceutical coverage and outpatient services. ***Figure 2*** below provides an overview of national Medicaid spending by population. Nationally, the elderly and people with disabilities comprise one-quarter of beneficiaries and account for 70 percent of Medicaid spending for services.

Figure 2. National Medicaid Enrollees and Expenditure by Enrollment Group, 2002



Source: Kaiser Commission estimates based on CMS and March 2003 CBO data.

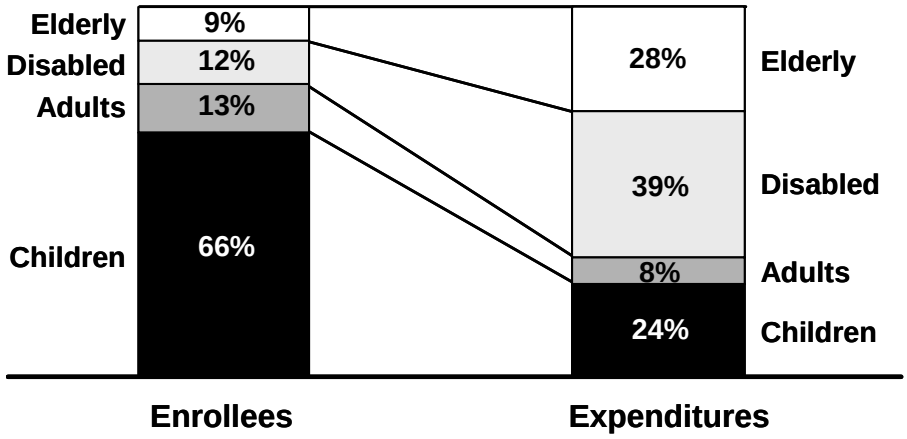
* Expenditure distribution based on CBO data on federal Medicaid spending for services only, excluding DSH, vaccines for children, administration and other provider payments. State share of total estimated using historical state share data.

In Indiana, approximately 733,729 residents are enrolled in Medicaid, about 13 percent of the State's population. Of this total, 164,941 are persons who qualify on the basis of age, blindness or disability. Spending for these persons of advanced age or with blindness or other disabilities accounts for 67 percent of Medicaid outlays; Indiana's ratio of aged, blind or disabled beneficiaries to the proportion of Medicaid funds expended on services for this group is in keeping with national figures. In federal fiscal year (FFY) 2002, Indiana Medicaid expenditures totaled $3.8 billion dollars in combined federal and state funding for Medicaid medical costs only; $1.42 billion was spent on services for LTC populations. [6] [7] See ***Figure 3***, below for Indiana spending by population.

[6] Total costs for the Medicaid program include both medical and administrative expenditures. This data represents only the medical costs of the program. (OMPP data.)

[7] In FFY2003 and FFY2004, Indiana was responsible for approximately 35 percent of its Medicaid costs; the federal government contributed approximately 65 percent.

Figure 3. Indiana Medicaid Enrollees and Expenditure by Enrollment Group, 2002



Source: OMPP data

A. Long Term Care Service Financing

Increasingly tight state budgets have left Medicaid programs throughout the country struggling to provide care both to current beneficiaries and to address growing demand from potential enrollees. Trends driving growth in demand for LTC services include:

- ***Utilization of services is rising.*** Life expectancy among persons with disabilities of all ages is increasing. This means that individuals enrolled in service programs, including HCBS Medicaid waivers, will receive services for more years than in the past. The outcome is a more rapid increase in demand than one would find based on population growth alone.
- ***Waiting Lists.*** A key outcome of the phenomenon described above is the rapidly growing number of individuals and their families on waiting lists for Medicaid-financed services delivered through Home and Community-Based Waiver programs.
- ***Aging and Growing Demand for Services.*** Aging has a two-pronged impact on the demand for services. First, the graying of America is a widely known demographic trend and our aging society directly impacts the need for LTC services. As noted above, family members provide the bulk of services to persons with disabilities; as these family caregivers age and their ability to provide support decreases, appropriate services must be available to assist them.

1. State Actions Related to Demand Growth

To address these challenges, every state has made alterations in its Medicaid program to contain costs. Despite programmatic trimming, states are anticipating budget shortfalls totaling about $40 billion in 2005.[8] Historically, very few cost containment activities were focused on controlling spending on LTC services. However, more states are looking to LTC programs for

[8] Smith, V., et. al. "The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005," Kaiser Commission on Medicaid and the Uninsured, October, 2004.

cost containment opportunities, as they have exhausted other options. Cost control initiatives are targeting both institutional care and home and community-based services. Institutional cost control initiatives, implemented by eight states in FY2004 and expected in 11 states in FY2005, include reductions in capacity, tightened eligibility criteria, and reduced provider payments. Home and community-based cost controls include freezing waiver slots, limiting authorized hours of service, reducing budgets, and utilization review. These changes in particular contrast with state actions over the past five years to expand access to home and community-based services; they were implemented by eight states in FY2004 and are planned in 11 states in FY2005.

Overall, Medicaid spending on LTC services in 2002 accounted for more than one-third of total Medicaid spending, more than double the proportion going to these services in 1991.[9] In Indiana, LTC spending accounted for 38.6 percent of total Medicaid expenditures, slightly higher than the national average of 37.5 percent.

2. Medicare and Medicaid for Persons who are Aged, Blind or Disabled

Many individuals who are eligible for Medicaid on the basis of age or disability are also eligible for the federally administered Medicare benefit. Medicare does not provide coverage for ongoing LTC services;[10] on a national basis, the joint federal-state Medicaid programs cover the care of nearly 70 percent of all nursing facility residents and finance over 50 percent of the revenue base of the nursing home industry. For individuals who are "dually eligible" for Medicare and Medicaid, Medicare covers acute care services, such as visits to doctors' offices and acute inpatient care. Medicaid covers LTC services such as nursing home placements and other important services and products, such as ongoing personal care services and pharmaceuticals that the Medicare program does not cover.

Medicare Modernization Act

The Medicare Modernization Act (MMA), enacted on December 8, 2003, established a new prescription drug benefit for Medicare beneficiaries and launched far-reaching reform of the Medicare program. The MMA's provisions also have important long term consequences for the Medicaid program, particularly for beneficiaries eligible for benefits under both Medicaid and Medicare who will now receive prescription drug coverage through the federal Medicare program.

Dually eligible individuals are more likely than Medicare-only beneficiaries to need assistance with activities of daily living and to have multiple chronic conditions such as heart disease, diabetes, and mental health or cognitive impairments.[11] Nationally, in 2002, there were approximately 6.2 million dually eligible individuals. These beneficiaries represented 17.2 percent of the Medicare population and 24

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9 Schneider, A. & Elias, R. "Medicaid as a Long-Term Care Program: Current Benefits and Flexibility," Kaiser Commission on Medicaid and the Uninsured, November 2003, p. 4.

10 Medicare covers care in a skilled nursing facility (SNF) under certain circumstances for a limited time. Skilled care services that are needed daily on a short-term basis of up to 100 days are covered if the beneficiary has Medicare Part A coverage, had a qualifying hospital stay prior to entering the SNF, requires daily skilled care ordered by a doctor, receives care in a Medicare-certified SNF, and was treated for the condition during the qualifying hospital stay acquired the condition while receiving Medicare-covered SNF care. Beneficiaries face no copayments for days 1-20 of SNF care and copays of $109.50 per day for days 21-100. After day 100, beneficiaries pay the full amount.

11 Activities of Daily Living (ADLs) are the basic tasks of everyday life. ADLs include eating, dressing, bathing, transferring, and toileting. Measurement of ADLs is used by health care professionals to assess levels of functional impairment for persons of advanced age and/or disabilities. Deficits in ADLs are used, in part, to determine functional eligibility for long term care programs and to develop plans of care.

percent of Medicare costs. In terms of Medicaid, dually eligible individuals represented 18.9 percent of Medicaid beneficiaries in 2002 and 35 percent of Medicaid costs.[12] In 2002, there were 105,000 dually eligible individuals in Indiana, at a cost of about $1.6 billion in combined federal and state spending.[13] For dually eligible individuals, Medicaid is responsible for costs not covered under Medicare, including Medicare premiums, pharmacy, and LTC.

Dually eligible beneficiaries are likely to be affected both by the establishment of the new Medicare prescription drug benefit, which will vary in a number of ways from their coverage under Medicaid, and by the reforms to Medicare's managed care program, which are intended to give all Medicare beneficiaries a range of new coverage choices. Lewin accounted for the provision of the new Medicare drug benefit to dually eligible individuals in its cost modeling.

B. Long Term Care Service Delivery

LTC services are delivered under both mandatory and optional state Medicaid plan benefits.[14] See ***Table 3*** below. As state plan benefits, these services, both mandatory and optional, are considered an entitlement and must be made available statewide to all individuals found eligible within 90 days of application. The one exception to the entitlement nature of state plan benefits is Targeted Case Management; states have special flexibility to "target" this benefit to particular populations and/or geographic regions.

[12] University of Maryland Center on Aging Medicare/Medicaid Integration Program website. Accessed on March 31, 2004.

[13] "Dual Eligibles Tables: Enrollment and Spending, by State, 2002," Kaiser Family Foundation, January 28, 2004.

[14] Under federal law, all states operating a Medicaid program must offer mandatory services. States have the flexibility to choose to offer optional services.

Table 3. Medicaid Long Term Care Benefits

Mandatory Items and Services	Optional Items and Services
Institutional Services	***Institutional Services***
Nursing Facility services for persons over age 21	Intermediate care facility for individuals with mental retardation (ICF/MR) services Inpatient and nursing facility services for individuals 65 or over in an institution for mental diseases Inpatient psychiatric hospital services for individuals under age 21
Noninstitutional Services	***Noninstitutional Services***
Home Health Care services for everyone entitled to nursing facility services	Home health care services Case management services Respiratory care services for ventilator-dependent individuals Personal care services Private duty nursing services Hospice care Services furnished under a PACE program Home and community-based services (under budget neutrality waiver)

Source: Schneider, Andy and Elias, Risa. "Medicaid as a Long-term Care Program: Current Benefits and Flexibility." Kaiser Commission on Medicaid and the Uninsured. November 2003, p. 4.

In addition to state plan benefits, Section 1915(c) of the Social Security Act allows the federal Department of Health and Human Services to approve federal Medicaid matching payments for certain LTC services that would not otherwise qualify for federal financial support. Section 1915(c) waivers, typically called home and community-based services waivers, "waive" certain provisions of federal law. Provisions of federal law which may be waived include:

- *State plan benefits must be available statewide.* Waiver services may be targeted to only parts or a part of a state.
- *State plan benefits are an entitlement and must be provided to everyone who is found eligible.* Services designed and delivered in a home and community-based services waiver program may be delivered to a limited number of individuals. Stated another way, states may "cap" the number of waiver participants. Caps may be established using either a set number of waiver participant "slots" or a state may use the waiver program's funding appropriation to specify the total number of people eligible for the waiver. States also may target HCBS waivers to particular groups of people; these groups are: a) aged or disabled or both; b) mentally retarded or developmentally disabled or both; or c) mentally ill.[15] States also have flexibility in establishing targeting criteria consistent with this regulation. States may define these criteria in terms of age, nature or degree or type of disability, or other reasonable and definable characteristics that sufficiently distinguish the target group in understandable terms.[16]

[15] 42 CFR 441.301(b)(6)

[16] State Medicaid Directors' Letter Number 01-006 dated January 10, 2000.

- *State plan benefits must be made available to meet all of a beneficiary's assessed needs and a state may not limit the scope or duration of services below any federal limitations.* In home and community-based services waivers, states may define service limitations as long as the health, safety and welfare of home and community-based services waiver participants are guaranteed. Under HCBS waiver programs, states are obligated to provide all people enrolled in the waiver with "the opportunity for access to all needed services covered by the waiver and the Medicaid state plan based on an assessment." States cannot develop separate and distinct service packages for waiver population subgroups within a single waiver. The opportunity for access pertains to all services available under the waiver that an enrollee is determined to *need* on the basis of an assessment and a written plan of care/support.[17]

However, waivers do not create new eligibility groups. Participants must be categorically eligible for Medicaid (i.e., over age 65, disabled, or a child with a special need). Additionally, home and community-based services waivers, and the services they include, are considered alternatives to institutional care, such as nursing homes. Functional eligibility for a waiver must be associated with an institutional alternative such as a nursing home, hospital, or intermediate care facility for persons with mental retardation (ICF/MR).

The tools states use to identify individuals who need nursing home, hospital or ICF/MR services or their HCBS alternatives are Level of Care (LOC) assessments. States must either use the same tool for assessing individuals for institutional services and the HCBS alternative or use two tools that have been found to be equivalent.

The federal government also places limits on waiver costs in relation to institutional costs. Waiver costs may not exceed the cost of services had participants been served in an institutional setting. Waiver services are provided in participants' homes and in the community including workplaces. All states, except Arizona, have at least one Section 1915(c) HCBS waiver; today, Indiana operates eight such waivers.

C. Long Term Care Service Delivery Trends

From the 1960's, when Medicaid was established, through the early 1980s, the primary vehicles for LTC service delivery were institutional settings, such as nursing homes, ICFs/MR, and hospitals. Today, most states no longer solely emphasize institutional care and have developed or expanded non-institutional LTC services such as Medicaid-financed state plan option personal assistance services and mandatory home health care benefits, and optional HCBS waivers. Since 1991, HCBS waiver expenditures have grown from five percent of national Medicaid spending to 19 percent, or $14.4 billion, in 2002.[18]

States have pursued non-institutional system development to:

[17] Ibid.

[18] U.S. General Accounting Office, "Long-Term Care: Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should Be Strengthened," GAO-03-576, June 2003.

- Honor consumer and family preference for HCBS over institutional services;
- Pursue HCBS development that, on average, when grown within a broader LTC cost containment strategy is generally less costly than institutional services; and
- Respond to the Supreme Court's 1999 ***Olmstead*** decision.[19]

D. Indiana Long Term Care Trends Overview

In response to the ***Olmstead*** decision, the Governor of Indiana issued an Executive Order in September 2000 naming the FSSA responsible for ***Olmstead*** planning and requesting the agency's recommendations by June 1, 2001. FSSA's recommendations included six policy directives:

- Emphasize consumer choice by enabling individuals to receive the types of services they desire in the location they prefer;
- Provide information, assistance and access to consumers to increase their opportunity for informed choice;
- Support the informal network of families, friends, neighbors and communities;
- Strengthen quality assurance, monitoring systems, complaint system, and advocacy efforts;
- Increase the system capacity for provision of high-quality care; and
- Create a coordinated workforce development system that recruits and supports a stable resource of direct support staff.

In July 2002, the governor appointed the 21-member Governor's Commission on Home and Community-Based Services to develop strategies aimed at the creation or expansion of community-based services for persons with disabilities. The Commission released an interim report in December 2002, and a final report in June 2003. These reports identified specific recommendations and actions to improve community-based options in Indiana.[20]

The interim report of the Governor's Commission highlighted sixteen specific recommendations that had been identified and studied. These were grouped according to themes, including eligibility, streamlining or maximizing funding, developing provider incentives to increase capacity, consumer education, and consumer choice. Then the final report of the Commission provided the current status of each of those recommendations and presented twenty-eight actions to serve as a blueprint for LTC reform in Indiana. The actions were grouped in four categories: 1) rebalancing the LTC system; 2) removal of barriers; 3) community capacity; and 4) children at risk. As part of its ***Olmstead*** initiative, Indiana has substantially increased its HCBS spending; ***Table 4*** below provides an overview of Indiana LTC spending.

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[19] In June 1999, the U.S. Supreme Court issued a ruling under the Americans with Disabilities Act (ADA) that requires states to provide long term care services in the most community-integrated setting.

[20] HCBS Clearinghouse for the Community Living Exchange Collaborative, "Indiana 2003: The States' Response to the Olmstead Decision: How Are States Complying?" http://www.hcbs.org/htmlFile.php/fid/738/did/137/ (accessed 6/23/2004).

Table 4. Medicaid Long Term Care Expenditures, Indiana
Actual and Projected, Fiscal Years 2000-2005

	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
	(millions)					
Nursing Home Services	$774.1	$813.5	$842.0	$795.8	$815.3	$856.1
ICF/MR	$279.5	$302.3	$332.2	$341.4	$344.4	$359.7
Home Care	$48.8	$51.2	$52.9	$55.7	$60.1	$64.8
All HCBS Waivers	$104.1	$133.2	$175.3	$276.9	$366.2	$431.7
Aged & Disabled HCBS Waivers[1]	$16.7	$17.7	$20.4	$30.7	$40.5	$43.1
Total Long Term Care	$1,206.5	$1,300.2	$1,402.4	$1,469.8	$1,586.0	$1,712.3
	(percentage)					
Nursing Home Services	64.2%	62.6%	60.0%	54.1%	51.4%	50.0%
ICF/MR	23.2%	23.3%	23.7%	23.2%	21.7%	21.0%
Home Care	4.0%	3.9%	3.8%	3.8%	3.8%	3.8%
All HCBS Waivers	8.6%	10.2%	12.5%	18.8%	23.1%	25.2%
Aged & Disabled HCBS Waivers	1.4%	1.4%	1.5%	2.1%	2.6%	2.5%
Total Long Term Care	100%	100%	100%	100%	100%	100%

Source: Lewin calculations from State of Indiana Office of Medicaid Policy and Planning, *Budget Analysis Report for Fiscal Years 2002 Through 2005,* December 19, 2002 (prepared by Milliman USA, Inc. and updated January 29, 2004).

[1]Aged & Disabled HCBS Waiver expenditures for FY2000 and FY2001 from Brian Burwell, Kate Sredl, and Steve Eiken, *Medicaid Long Term Care Expenditures – FY2003,* May 25, 2004, http://www.hcbs.org/files/35/1707/2003StateExpenditures.xls

Columns may not add to totals due to rounding.

1. Institutional Long Term Care Spending in Indiana

Despite HCBS expansion, Indiana continues to invest a significant amount of its Medicaid LTC budget in facility-based care. Considering institutional services together (nursing facilities and ICFs/MR), in FY2003, Indiana spent approximately 77 percent of its LTC Medicaid dollars on facility-based services. Most of the institutional costs are driven by the ICF/MR program; eliminating ICF/MR expenditures reveals a decrease in nursing home costs (see *Table 4* above). Driving this decrease is an array successful strategies aimed at reducing nursing home utilization; two of these strategies are discussed below.

a. Diversion

One strategy involves diverting individuals into home and community-based care by providing necessary information and services before they enter a nursing home. A key population to divert from nursing facilities is hospital patients who may need a nursing level of care after their discharge. Nationally, hospitals provide nursing homes with about 65 percent of all their

admissions;[21] in Indiana, this figure is slightly higher at 70 percent. States target this population by making case workers or social workers available to hospital patients who may potentially enter nursing facilities after their discharge. Diversion staff provide information and counseling on HCBS options and support consumers and families as they access HCBS.

In Indiana, working with hospitals to identify patients likely to enter nursing homes, AAA case managers provide information about HCBS to these individuals. Through this program, 316 people accessed home and community-based services in 2002.[22] Between state fiscal years 2003 and 2005, 1,516 individuals will have been diverted to home and community-based settings from nursing homes.[23] This initiative is part of a DDARS/OMPP Priority Diversion program where waiver slots are released and targeted to diverted individuals. The State uses a variety of funding mechanisms for this service including Medicaid-financed Targeted Care Management (TCM), a State Medicaid Plan benefit.

b. Transition

States also have developed initiatives to transition individuals out of nursing homes back into their homes and communities. Once consumers enter a nursing facility and stay for a few months, it becomes highly unlikely that they will leave, even if their needs change. Nursing home residents typically disburse resources and assets, such as a house and furnishings, cars, savings, etc., during their early stay in a nursing facility. To return to the community, all of these resources must be replaced. Additionally, residents and their families may become comfortable with the nursing home setting.

Nursing home transition programs must develop methods of identifying potential candidates, develop administrative and operational infrastructure including staff to serve as transition coordinators, identify funds to cover upfront moving costs (i.e., rent and utility deposits), and develop needed community-based services and related supports such as income assistance, transportation, medical care providers, etc. States experiences indicate that individuals who transition have not typically been long term residents, have some informal or natural supports currently available in the community, and do not have dementia.[24]

Indiana targets individuals specifically in nursing homes that are closing, focusing on residents that will need to find a new provider for their LTC services. The State has created Senior Care Teams for this effort, which includes case managers or staff from the local nursing home ombudsman, local Area Agency on Aging, the Department of Health, the state Medicaid agency, and the HCBS waiver operating agency. After a nursing facility gives its 30-day closure notice, Senior Care Teams are assigned to affected residents to discuss with them all their rights and options, and to help them find a new provider, whether it is community-based or another nursing facility. Indiana also has included in its A&D waiver a Community Transition benefit which covers some of the costs associated with moving from a nursing facility into an HCBS

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[21] The National Nursing Home Survey: 1999 Summary.

[22] Crisp, S., et al., Medstat, "Money Follows the Person and Balancing Long-Term Care Systems: State Examples, 2003."

[23] Memorandum from Melanie Bella, dated September 29, 2004, to the Indiana Government Efficiency Commission Subcommittee on Medicaid and Human Services

[24] Presentation by Steve Eiken, Thomson MEDSTAT, entitled "Lessons from the 1998-2000 Nursing Home Transition Grants," dated October 27, 2003.

program and has established a Transitions Director position. As of July 2004, 172 individuals have been transitioned from nursing facilities back in to the community.[25]

For both diversion and transition, case managers receive a one-time incentive payment of $500 per diversion or transition. Other strategies aimed reducing institutional spending are discussed below.

2. Impact of Institutional Spending Reduction Efforts

Overall, the Indiana Medicaid program continues to spend more than the national average on institutional care, primarily driven by its use of ICF/MR services. If ICF/MR is discounted, the State is spending more on HCBS and less on institutional care over time. As a percentage of total LTC expenditures, spending on nursing home services has decreased to 54.1 percent in FY2003 from 64.2 percent in FY2000. Nursing home spending is projected to decline further to 50.0 percent of total LTC expenditures by FY2005.

At the same time, Indiana Medicaid spending for HCBS waiver services increased as a percentage of total LTC expenditures, from 8.6 percent in FY2000 to 18.8 percent in FY2003. For the State's A&D HCBS waiver, spending has increased from $16.7 million (1.4 percent of total LTC expenditures) in FY2000 to $30.7 million (2.1 percent of total LTC expenditures) in FY2003. In comparison, in the U.S. as a whole in 2003, 22.2 percent of total Medicaid LTC expenditures was spent on HCBS waiver services, with 5.0 percent going toward A&D HCBS waivers. ***Table 4***, above, shows actual and projected LTC expenditures in Indiana, along with the proportion of the total accounted for by institutional versus HCBS.

[25] Ibid.

III. HOME AND COMMUNITY-BASED SERVICES IN INDIANA

Since the early 1980s, states have aggressively developed and expanded HCBS options, such as Medicaid waiver programs and state general fund community-based services, both in response to consumer requests and based on evidence that HCBS are more cost effective in the aggregate, especially when coupled with global LTC cost controls, such as reductions in nursing home spending. Indiana has eight HCBS waivers and a unique state general fund program for persons of advanced age and persons with disabilities – the CHOICE program - that provides non-institutional LTC services. Since 1994, the number of individuals served annually through CHOICE and the A&D Medicaid waiver has more than doubled.

Compared to other states, Indiana was late to begin offering Medicaid HCBS waiver services. Most states began implementing HCBS waivers in the early- to mid-1980s; Indiana implemented its first waiver in 1989. ***Table 5*** below provides an overview of Indiana's current waivers.

Table 5. Indiana Home and Community-Based Services Waivers

Waiver	Service Population	Enrollment	Waiting List
Aged and Disabled	Persons age 65 and older and persons with physical disabilities.	3,321	2,000
Developmental Disabilities	Persons with MR/DD of all ages.	5,269	12,970
Autism	Persons with Autism of all ages.	339	2,523
Medically Fragile Children	Children with long term, special health care needs.	101	848
Traumatic Brain Injury	Adults with brain injuries.	145	280
Assisted Living	Persons age 65 or older.	78	50
Support Service Waiver	Persons with MR/DD of all ages.	3,567	8,416
Severe Emotional Disturbance	Children with severe emotional disabilities.	0	0

Source: FSSA, DDARS Indiana FACT Sheet on HCBS Programs, State Fiscal Year 2005 Cumulative, 1st Quarter.

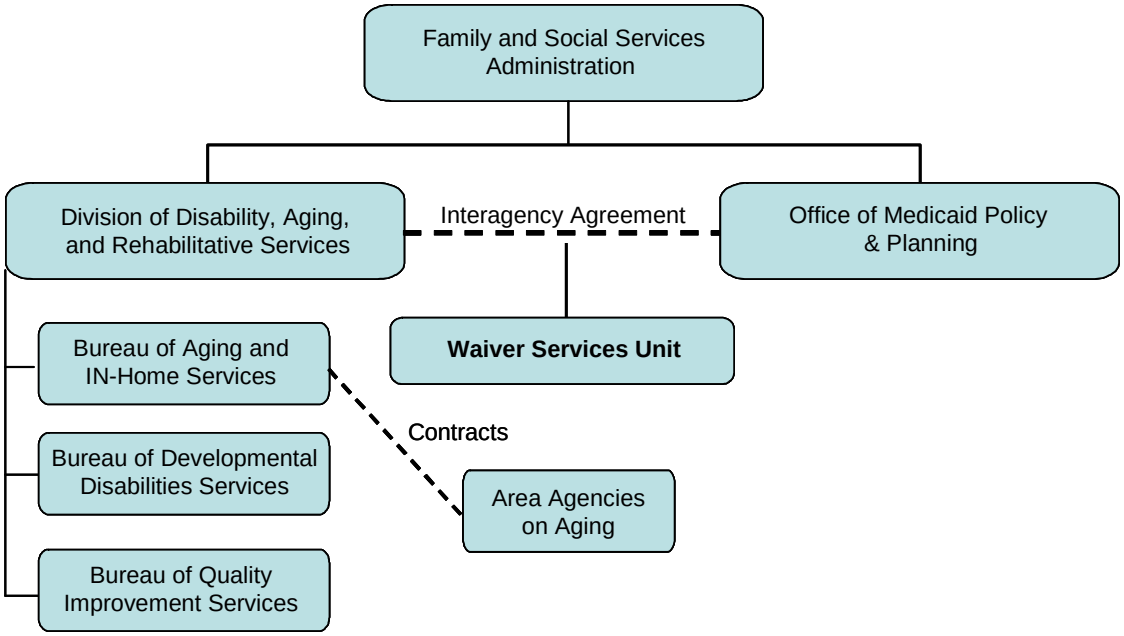
While some waivers serve similar populations, each waiver has a distinct set of services and important policy goals and service outcomes. Additionally, eligibility parameters vary among waivers.

Indiana's A&D HCBS Waiver was instituted in 1992. Its purpose is to provide home and community-based services to aged or disabled individuals who, without those services, would require care in a nursing facility. The waiver allows persons of advanced age and persons with physical disabilities to receive LTC services in their homes and communities rather than enter a nursing facility that may or may not be close to their families.

A. Administration and Authority

Indiana is undergoing significant reorganization of its Medicaid home and community-based waiver services. Prior to this year, DDARS operated four of the eight Medicaid HCBS waivers plus the CHOICE program, while the remaining waivers were administered by other FSSA divisions. But now, a single Waiver Services Unit will operate all eight waivers. In January 2004 OMPP and DDARS began work on a plan to operate all Medicaid HCBS waivers under this single management umbrella. The rationale for the change includes serving more people, streamlining procedures, reducing duplication of efforts, improving the quality of services, and coordinating staff training and competency development. The following sections offer information about the current structure and changes that have been made to date. Administrative responsibility for the HCBS A&D waiver is shown is the following diagram *(**Figure 4**)*, which is discussed further below.

Figure 4. Administrative Responsibility and Agency Relationships, Aged & Disabled HCBS Waiver



1. State Level

In Indiana, LTC services for persons of advanced age and persons with disabilities are administered primarily by the DDARS, through the Statewide IN-Home Services Program, a program of the Bureau of Aging and IN-Home Services (BAIHS).

Table 6. Home and Community-Based Services Responsibilities and Authority

Department or Agency	Tasks Related to Home and Community-Based Services	Authority Mechanism
Department of Family and Children	Financial Eligibility	State Statute
AAAs under contract to FSSA	Functional Eligibility	State Statute
Office of Medicaid Policy & Planning (OMPP) [Indiana Medicaid Agency]	Waiver Services is a new unit created in January 2004 to consolidate the management and operations of Indiana's home and community-based services waivers. A proposal for coordination of waivers administered by BAIHS, BDD, and OMPP was written in an effort to address the fragmented operational structure of waiver administration and to make long-term changes to benefit waiver administration for OMPP and DDARS.	Interagency agreement (MOU) with DDARS
Division of Disability, Aging, and Rehabilitative Services (DDARS) *Bureau of Aging and IN-Home Services (BAIHS)* *Bureau of Quality Improvement Services (BQIS)*	Operates in-home services and community-based programs for older adults and persons of all ages with disabilities. Administers A&D HCBS waiver. *Administers the Statewide IN-Home Services Program. Sets requirements and standards for service providers. Certifies providers.* *Responsible for waiver quality strategies*	Interagency agreement (MOU) with OMPP
Waiver Services Unit	Blended unit of OMPP and DDARS staff responsible for waiver administration	Interagency agreement (MOU) between OMPP and DDARS
Area Agencies on Aging (AAA)	Single points of entry for community-based LTC services for A&D; plans of care subject to approval by OMPP. Responsible for: budgeting, case management, oversight, monitoring, quality assurance, submission of fiscal claims to DDARS. Arrange for provision of services through local vendors.	Currently: contracts with DDARS and Waiver provider agreements; will be streamlined under Waiver Services Unit

As the single state Medicaid agency, OMPP has significant responsibility for Medicaid Waiver services. OMPP develops and coordinates all policy related to home and community-based services. The agency also has responsibility for approving all formal Medicaid Waiver requests, amendments, and renewals before they are submitted to the federal Centers for Medicare and Medicaid Services (CMS). Before the Waiver Services Unit consolidation, OMPP conducted quality assurance on waivers it directly administered while BQIS in DDARS handled quality for other waiver programs. However, as part of its Medicaid agency responsibilities, OMPP reviews all waiver expenditure reports, and is responsible for payment of claims and billing inquiries for all waiver programs. As the Medicaid agency, OMPP also is responsible for administering the hearings and appeals processes for Medicaid beneficiaries including A&D waiver participants.

Like most state Medicaid agencies, OMPP delegates day-to-day responsibilities to "operating agencies" for several waivers. The A&D HCBS waiver is one of the waivers that DDARS operated before the Waiver Services Unit consolidation. Previously, DDARS developed and enforced standards for providers and reviewed all plans of care for safety and feasibility. The

Division was responsible for ensuring quality, plans of care, and freedom of choice. It also approved and enrolled new HCBS providers, trained case managers, and drafted HCBS waiver amendments, renewals, and new proposals subject to OMPP approval. The Division also assisted OMPP with developing new policies, setting rates, and identifying new services to be offered. It also maintained data sets of recipients, expenditures, and other information.

BAIHS responsibilities, however, went beyond just A&D waiver operations. The agency still administers the statewide IN-Home Services Program and brings together funding from a variety of sources including the A&D Medicaid waiver administrative funds for AAAs, CHOICE, Social Services Block Grant (SSBG) funds, and Older Americans Act funds.[26] The DDARS/BAIHS Statewide IN-Home Services Program focuses on prevention, early intervention, protection, and advocacy to allow people in need of care to maintain their independence to the greatest extent possible.

Direct consumer contact functions (i.e., assessment, intake, service planning, etc.) take place through contracts between the FSSA and the state's 16 AAAs, each with its own catchment area where it serves as a single point of entry (SEP) for aged and disabled LTC services. The AAAs use the Long Term Care Services Eligibility Screen to assess eligibility and need for services under the various programs.

As noted above, in addition to administering the Medicaid HCBS waivers, the DDARS/BAIHS Statewide IN-Home Services program also administers CHOICE, a non-Medicaid, State General Fund program. Funding for CHOICE flows through the DDARS budget, and DDARS/BAIHS contracts with the state's 16 AAAs to administer CHOICE funds. Information on CHOICE services is primarily maintained at the local level in the AAAs. Each AAA must submit a CHOICE plan to DDARS/BAIHS; the plan (or updates to the plan) must be approved before implementation.

2. Local Level

Access to home and community-based programs for older persons and persons with disabilities is accomplished through Indiana's network of 16 local AAAs. The AAAs are private, non-profit agencies that contract with the Waiver Services Unit to serve as the SEPs for A&D waiver services. In addition to the SEP functions, AAAs are also direct providers of services. Through the AAA network, services are integrated and coordinated through service delivery planning that looks at needs over a continuum from those needing relatively minimal supports up to individuals with high needs, such as those who qualify for HCBS waiver services.[27]

Additionally, day to day administration and coordination of HCBS, including the A&D Waiver and CHOICE, takes places through the AAA network. Through the AAA-BAIHS contract, the

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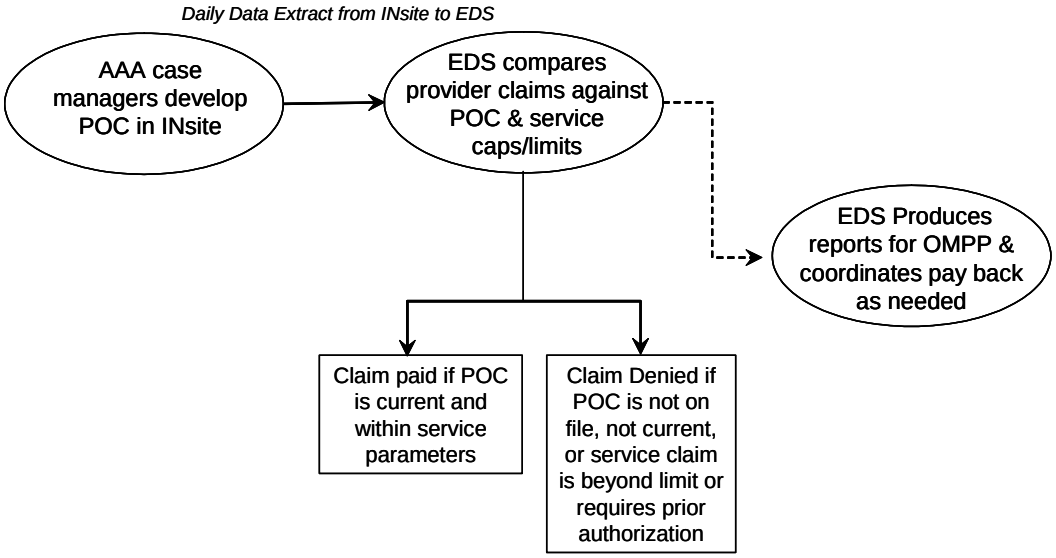
[26] Social Service Block Grants are federal dollars administered by the Administration on Children and Families in the U.S. Department of Health and Human Services (DHHS). Once a key source of HCBS funding, these funds are now used primarily as stop-gap dollars for various HCBS programs as long as they are not used as matching funds for other federal programs. Older Americans Act (OAA) funds are an array of funding streams to states from the federal Administration on Aging, also within DHHS. These OAA grants underwrite case management, meal services, transportation, respite, caregiver supports, and some in-home services.

[27] Indiana Family and Social Services Administration, "Statewide IN-Home Services 2002 Annual Report, July 1, 2001 – June 30, 2002."

AAAs determine functional eligibility, provide initial case management services, complete intake and arrange for assessments, and participate in the development of plans of care (POC). See ***Figure 5,*** below, for a depiction of how plans of care are submitted and used in the waiver service provider claims payment process.

Figure 5. Plan of Care Review and Waiver Payment Strategy



The AAA-BAIHS contract provides an annual amount of funding to each AAA in exchange for performing CHOICE administrative functions. Similar to the functions they perform for waiver, the AAAs are responsible for organizing assessment activities, coordinating involvement of various parties in the assessment process, arranging service contracts through Memoranda of Agreement with provider agencies, ensuring the provision of necessary long term community support services, providing ongoing case management, periodic case plan review and follow-up services, applying the CHOICE cost sharing plan, making CHOICE program information available, planning to meet the needs of all CHOICE groups, coordinating the program with other programs and service systems, ensuring appropriate program reporting, billing, and budget reconciliation, and implementing quality assurance procedures.[28] An important distinction between AAA waiver responsibilities and CHOICE is that AAAs set CHOICE service units and rates following the statewide list of CHOICE services and service definitions. Waiver rates are statewide and are set by the State.

Included in the AAAs' responsibilities for administration of the waiver programs are reporting elements on program performance and quality monitoring. Specifically, AAAs are required to:

- Report all program applications and case manager notes into the State's INsite data system;

[28] Community and Home Options to Institutional Care for the Elderly and Persons with Disabilities (CHOICE) Guidelines and Procedures, Revised June 1, 2001.

- Maintain waiver and CHOICE waiting lists through INsite. At this time, however, the state is in the process of assuming responsibility for maintaining the waiting list in an effort to streamline the process and more efficiently distribute waiver slots. AAAs remain contractually required to report requests for services but will not have the final responsibility for maintaining the waiting list;
- Maintain a list of participating providers;
- Conduct client satisfaction surveys for 5-10 percent of all waiver participants; and
- Participate in waiver quality reviews conducted by the State Audit Services, Bureau of Aging and IN-Home Services and DDARS/BQIS.

For all responsibilities, the AAAs operate autonomously, and State staff report that there is significant local variation in how the State's AAAs perform intake and deliver services. In an effort to reduce variation in some areas, the State is revising its current contract with the AAAs. The revised contracts will be annual, rather than two-year, and will have more specific criteria on performance of AAA functions.

3. Quality Assurance

A 2003 GAO report identified problems in the quality assurance strategies of waivers targeted to persons of advanced age and persons with physical disabilities at the national level. These issues include problems in waiver oversight at CMS, the federal agency responsible for waiver approvals and renewals. The report found that there are no nationwide data available on state quality assurance practices or on quality of care for aged waiver beneficiaries. In an analysis of CMS and state reports, common quality problems included (1) failure to provide authorized or necessary services, (2) inadequate assessment or documentation of care needs, and (3) inadequate case management. In addition, CMS has not fully complied with requirements that waiver renewals depend on states submitting annual reports and CMS conducting and documenting periodic waiver reviews.[29] Not surprisingly, since issuance of this report, CMS has beefed up its review process for A&D waivers and has included a new quality section in the draft, revised Section 1915(c) waiver application currently being reviewed by state aging, developmental disabilities and Medicaid agencies.

Currently, Indiana's key waiver quality approaches are administered by BQIS and the AAAs, as part of their contract responsibilities. BQIS has a staff detail of three supervisors and fifteen staff who oversee or perform quality assurance tasks for the four DDARS administered waivers. These four waivers include those for traumatic brain injury, aged and disabled, assisted living, and medically fragile children. As the new Waiver Services Unit develops, all waiver quality will be administered from BQIS.

Indiana uses a variety of quality assurance techniques for its Medicaid waiver programs. However, while many have been instituted for other waivers, few are in place for the A&D HCBS waiver. Many of the techniques and tools will be added for the A&D waiver in the near future through a three-year, $500,000 CMS Real Choice Systems Change Grant received in Fall

[29] U.S. General Accounting Office, "Long-Term Care: Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should Be Strengthened," GAO-03-576, June 2003.

2003. The grant covers the four waivers that were administered by DDARS/BAIHS, including the A&D Waiver. The grant-funded project proposes five goals: building quality into the system; allowing for expeditious evaluation and action; allowing data analysis by staff to identify patterns; automated data collection, synthesis and storage; and project monitoring. The grant will allow the State to establish quality assurance activities in other waivers that have previously been taking place only in the MR/DD waiver.

Indiana's current quality assurance activities for the A&D HCBS Waiver include:

- **Review of waiver providers by EDS:** EDS, under contract with OMPP, serves as the fiscal agent for the Medicaid waivers and also conducts a review of the waiver providers as part of OMPP's monitoring and oversight of the A&D waiver.[30] Any issues identified in EDS' reviews are submitted to BQIS for follow-up. Follow-up involves the case manager, the provider, BQIS, BAIHS, and other entities. Additionally, BAIHS reviews 10-12 percent of automatic approval cases by: (1) verifying the client's condition; (2) determining whether services are meeting the client's needs; and (3) conducting home visits.
- **Complaint process:** Currently, BQIS has one full time staff responsible for processing complaints for all four waivers.
- **Quality Improvement Process (QIP):** Ten percent of recipients of services under the A&D waiver are surveyed using QIP, a participant feedback report. The survey is administered in person by case managers, generally during the recipient's annual reassessment. Questions are asked in five domains: choice; timeliness; respectfulness; consistency; and task performance. Each AAA must survey five percent of its home and community-based services recipients to assess client satisfaction in the areas of service quality and provider dependability. Feedback is given to providers in an aggregated (unidentifiable) format to assure quality and to improve services.[31] BQIS staff indicate this information is only marginally utilized.
- **90-day checklist:** Case managers complete a 90-day checklist for every recipient.

Under a rule being developed by BAIHS under the quality grant (460 IAC 1.1), additional quality assurance activities that will be added to the A&D waiver include:

- **Provider surveys:** Three survey tools are used to collect data about providers (i.e., AAAs), safety, and quality of care for providers in the developmentally disabled waiver. The provider surveys will cover agency policies and procedures, staff training, and agency quality assurance and improvement processes. Residential providers will be reviewed for up-to-date service plans, behavioral support plans, and current assessments; similar materials will be reviewed with vocational providers. There also will be interviews with consumers as well as with staff to ensure knowledge of POCs and behavior plans. These tools result in written correspondence to the provider

[30] Renewal, April 2003.

[31] Indiana's Quality Improvement Process (QIP), Vol. 1, No. 5, June 2003.

identifying any corrective actions needed. These are planned to be used for the A&D waiver as well.

- **Pre- and post- transition checklists:** Checklists are currently used in the waiver for the developmentally disabled to assess facilities both before and after a transition from an institutional setting. The grant also will fund a transition assessment for nursing homes. Currently the Waiver Services Unit receives monthly reports on transition and diversion consumers. This component will add another layer of review.
- **Ombudsman:** The developmentally disabled waiver also currently includes an ombudsman. This will be added for the A&D waiver as well.
- **Participant Experience Survey:** Indiana will be using the CMS-developed Participant Experience Survey (PES) to monitor several aspects of quality in their waiver programs. This survey will allow them to be able to look at trends in quality of service. These surveys are collected throughout the year. BQIS will be surveying 10 percent of people on all four waivers. BQIS Quality Monitors will get a list each quarter of the individuals to survey, and an annual report will be created. The goal is to survey 20 percent annually. PES identifies areas in which program participants are experiencing unmet needs or other problems and provides indicators of participants' experience in four domains: access to care, choice and control, respect and dignity, and community integration.
- **Incident reporting:** All incidents with harm or potential for harm will have to be reported. As of now, there is no reporting database. Two new staff will be responsible for this, under the supervision of an existing supervisor. This is also part of the quality grant; they are waiting for the rule to be promulgated.

  Size of the BQIS staff detail for the enhanced A&D quality efforts is based on the size of the CMS grant. Once BQIS implements the developmental disabilities quality strategies for the A&D waiver as well, staff hope to consolidate operations and anticipate efficiencies to be realized among the waiver staff.

4. Waiting Lists and Service Access Litigation

In recent years, States have experienced a steady stream of lawsuits asserting claims to HCBS on behalf of persons of advanced age and people with disabilities. Many lawsuits challenge state practices that limit access to Medicaid-financed HCBS, and complaints are based on provisions of the Medicaid statute. Other individuals and advocacy organizations have filed complaints on the basis of the ADA and the 1999 Supreme Court decision in ***Olmstead*** which laid out a three-part test for determining whether a state is serving a person in the most integrated setting appropriate. Still others challenge state policies that prevent individuals with disabilities from obtaining the *full* range of community services.[32]

Indiana maintains waiting lists for all of its waivers, including the A&D waiver, as well as the CHOICE program (see ***Table 6***, above). According to a DDARS comparative review of selected statistics, 1,740 people were on the waiting list for the A&D Medicaid waiver in the fourth

[32] Smith, G.A. "Status Report: Litigation Concerning Home and Community Services for People with Disabilities," July 20, 2004. Available on-line at http://www.hsri.org/index.asp?id=news (Accessed 8/10/2004.)

quarter of state fiscal year (SFY) 2004 while, at the same point in time, CHOICE served 10,491 individuals. And as of April 2004, 11,111 people were on the waiting list for CHOICE.[33]

In July 2000, a class action lawsuit, ***Flores et. al. v. Humphreys*** (formerly referred to as ***Inch v. Humphreys***), was filed against FSSA on behalf of physically disabled individuals in Indiana who reside in nursing facilities or who are at risk of nursing home placement but want to live in integrated settings and receive services through Indiana's A&D HCBS waiver. The lawsuit specifically alleged that 2,000 individuals with disabilities were either on waiting lists for community services or kept unjustly in institutional settings and were thereby experiencing ADA-prohibited discrimination. It also alleged that new enrollments in the State's community programs had been closed for two years and that new applications were not being accepted. The case was settled in June 2003, with the State agreeing to expand the waiver program to serve an additional 3,000 individuals and to provide more information about community services to nursing facility residents. In addition, the settlement identifies specific criteria for assessing community support needs and requires the State to develop a quality assurance plan for completing these assessments. The settlement applies to all nursing facility residents eligible for the HCBS waiver program and individuals at imminent risk of nursing facility placement.[34]

5. Waiver Data and Tracking

a. Medicaid Administrative Data

Responsibility for various Medicaid programmatic functions is often spread over several entities – through MOU between the Single State Medicaid Agency (SSMA) and sister agencies as well as through contracts between vendors and the SSMA. Indiana Medicaid data on A&D waiver participants is spread across the following systems:

- Client financial eligibility data is housed in the Division of Family and Children in the State's antiquated Indiana Client Eligibility System (ICES).
- Provider billing and claims payment are handled by EDS under contract with OMPP. Indiana AIM generates cost and utilization reports.

Until recently, OMPP had only limited access to financial eligibility data on Medicaid participants including Aged, Blind and Disabled populations and FSSA continues to experience difficulties pulling and integrating data from various waiver-related sources.

b. Waiver Specific Systems

i) INsite

The major system for collecting and reporting data at the AAA level and at the state level is software called INsite, which was developed specifically for the IN-Home Services Program.[35]

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[33] Personal communication with Sherry Gray, BAIHS.

[34] Smith, G.A., "Status Report: Litigation Concerning Home and Community Services for People with Disabilities," July 20, 2004. Available on-line at http://www.hsri.org/index.asp?id=news (Accessed 8/10/2004.)

[35] INsite is administered by Roeing Corporation of Lafayette, Indiana. For more information on INsite, see www.roeing.com.

INsite is used mainly by case managers to perform tasks such as conducting assessments, preparing plans of care, maintaining client case notes and recording client data from plans of care. Some AAAs use INsite to manage local funding from counties, civic groups, and other entities. Numerous other "modules" are by-products of the case management function (e.g. Medicaid billing, local vendors, Medicaid waiver provider database, QIP, claims monitoring, and maintenance of waiting lists for both the Medicaid waivers and CHOICE). The AAAs use the waiting list module to keep track of waiting lists for various other programs in addition to CHOICE and the Medicaid waivers as well, including Title III of the Older Americans Act and the Social Services Block Grant.

DDARS maintains the INsite database driven by data from all case managers across the state, both independent case managers and those employed by AAAs. Only DDARS and OMPP staff link directly to the DDARS INsite server. Case managers are not connected directly to this server. DDARS and OMPP LTC Division staff both raise concerns about the validity of INsite data due to variations in how AAAs and independent case managers are loading data; they also note a lack of some reporting functionality.

ii) New Data System

Currently, FSSA is negotiating a contract to procure a new database system to replace INsite that would offer enhanced data quality monitoring tools and better reporting capabilities. At the same time, the state is developing a new AAA contract that will include more rigorous statewide AAA reporting requirements. FSSA staff believe this will increase the consistency and reliability of the new HCBS data system, which will include the A&D waiver.

B. Accessing Home and Community-Based Services

1. Eligibility

The A&D waiver serves individuals who: a) meet Medicaid financial eligibility standards; b) are either 65 years of age or older or have a physical disability; and c) whose age and/or physical disability meets level of care (LOC) standards of a skilled or intermediate nursing facility (i.e., three or more ADL limitations).[36] LOC determinations are entered into the INsite database and AIM; this information is not available in the DFC financial eligibility system, nor is LOC information available in ICES. Consumers apply for A&D waiver services at the AAA. The case managers forward waiver application packets to: a) DFC for financial eligibility determination; and b) to the OMPP LOC Unit for functional eligibility determination.

a. Financial

Under SEA 493, waiver income limits are now set at 300 percent SSI while CHOICE has no income limit. Assets allowed to qualify for the A&D waiver are set at $1,500 and $2,250 for a couple, and spousal impoverishment protections now apply to spouses of waiver recipients. For CHOICE, services are provided at no charge for beneficiaries with countable incomes at or

[36] Family and Social Services Administration, Office of Medicaid Policy and Planning, "Renewal Request for Aged and Disabled Home and Community-Based Services Waiver, Control Number 0210.90.R2," Version 06-95, Effective July 1, 2003-June 30, 2008, April, 2003.

below 150 percent of the federal poverty level (FPL); assistance is then reduced as income increases and phases out above 350 percent of the FPL.[37]

b. Functional

To be eligible for services under the A&D HCBS waiver in Indiana, adults must have difficulty with 3 of 14 activities of daily living (ADLs), while for the CHOICE program, a person must have difficulty with two of these activities.[38] Also for Medicaid, waiver recipients must meet eligibility requirements for a nursing facility, and must need HCBS to prevent institutionalization.

The AAAs perform functional assessments with a uniform tool across the state (the Long Term Care Eligibility Screen), provide case management, and complete a pre-admission screening of all nursing home applicants. When an applicant is authorized to receive services through the A&D Medicaid waiver or CHOICE, a case manager writes the service plan and brokers services. Medicaid waiver recipients may choose a private case manager, while CHOICE recipients may not. (However, most A&D waiver recipients choose not to use a private case manager.) Case management reportedly varies in its effectiveness among AAAs.

As described above, once an applicant is authorized to receive services through the A&D Medicaid waiver or CHOICE, a case manager writes the service plan and brokers services. CHOICE rules indicate that when an individual receiving services under CHOICE becomes eligible under a Medicaid HCBS waiver and begins receiving waiver services, he or she is no longer eligible to receive those services through CHOICE.[39]

2. Outreach

Indiana has few active outreach efforts for the A&D waiver or the CHOICE program. A web page has been created and resides on the state's web site; however, information on the programs is minimal. The AAAs are linked to a statewide toll-free number for consumers to access information about services. DDARS' highest priority goal for the IN-Home Services Program over the 2004-2005 biennium is to expand home and community-based services to an additional 1,000 seniors.[40]

3. Recipients

In FY2004, Indiana served 4,637 persons in the A&D HCBS Waiver, out of 6,000 slots. Average monthly expense per person was $644 in state fiscal year 2002, down from $848 in FY2001 (24

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[37] Tilly, J & Goldenson, S.M. The Urban Institute and The Lewin Group, "Home and Community-Based Services for Older People and Younger Adults with Physical Disabilities in Indiana: Final Report," February 26, 2001.

[38] The 14 ADLs and conditions considered for eligibility for Indiana's HCBS A&D Waiver and CHOICE include significant deterioration in health status, requirement for daily recording of intake/output of fluids and solids, required assistance with the administration of oxygen, assistance with medications, supervision or assistance to maintain safety due to confusion or disorientation, assistance with turning or repositioning to avoid skin breakdown, required passive range of motion exercise, constant medical monitoring, and assistance required with eating, transferring, dressing, bathing, or using the toilet.

[39] Community and Home Options to Institutional Care for the Elderly and Persons with Disabilities (CHOICE) Guidelines and Procedures, Revised June 1, 2001.

[40] BAIHS, "Indiana State Plan for Aging and In-Home Services, Fiscal Years 2004-2005," July 25, 2003.

percent decrease).[41] In comparison, in FY2002, 12,728 individuals received CHOICE services at an average cost per client per month of $556; 2,361 of these individuals also were eligible for Medicaid. In FY2003, 11,272 clients were served by the CHOICE Program at an average cost per client per month of $538, and 2,333 were also eligible for Medicaid.[42]

4. Plans of Care

A written plan of care is developed for each individual receiving care under the waiver. This Plan of Care/Cost Comparison Budget (POC/CCB) describes the medical and other services to be furnished, their frequency, and the type of provider who will furnish the services. The POC/CCB is subject to approval by the Medicaid agency. The POC/CCB is developed once an individual is targeted for a waiver slot and is found eligible. These are used for initial determinations, updates, and annual re-determinations. The POC/CCB includes a statement regarding Freedom of Choice, by which the recipient or guardian is able to choose his/her preference for institutional versus community care. The Medicaid waiver services case manager is responsible for explaining the services available in each type of setting.[43]

5. Services

CMS gives states the flexibility to define the services that are essential for their target populations under HCBS waivers. This allows a state to design programs specific to its unique characteristics. The most common services offered in HCBS waivers include respite care, environmental modification, case management, expanded medical equipment or supplies, expanded personal care, personal emergency response systems, transportation, homemaker services, adult day care, and habilitation. Indiana is among the states that historically have offered a relatively narrow set of services under their A&D HCBS waivers; in fact, Indiana's service definitions are set in state statute, which leads to difficulty in adding, removing, or redefining services. Information about the services provided under the A&D HCBS waiver in Indiana is listed in ***Table 7*** below. SEA 493 requires that the services provided under the waiver match those provided under the state-funded CHOICE program; interviews with various sources in the State indicate that all CHOICE services (except the "other services" category, discussed below) had been added to the A&D waiver prior to the passage of SEA 493.

State-funded programs often provide services either in very specific areas or broadly to fill gaps in Medicaid coverage. Indiana's CHOICE program covers a variety of services including adult day care, attendant care, home delivered meals, homemaker, respite care, home health services, home health supplies, and transportation. The program also includes a category called "other necessary services," which allows case managers to arrange for virtually any other service the recipient needs to stay at home. Reimbursement rates for CHOICE tend to be higher than those for the A&D waiver; CHOICE units and rates are set by AAAs while waiver rates are set by the State. As a result, providers generally are more willing to provide services under CHOICE than under the waiver, which creates issues with provider recruitment and retention.

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41 Indiana Family and Social Services Administration, "Statewide IN-Home Services 2002 Annual Report, July 1, 2001 – June 30, 2002."

42 Email from Gary Renegar, DDARS

43 *Ibid.*

Table 7. Services Available through Indiana's Aged and Disabled HCBS Waiver, with Reimbursement Rates, 2003-2004

Waiver Service	Definition of Service[1]	Estimated Annual Units Per User	Unit	Reimbursement Rate Per Unit
Case Management	Comprehensive coordination and integration of all other services; required for all recipients of waiver services	17	Hours	$37.58
Homemaker Services	Assistance with household tasks; provided when recipient and/or informal caregiver is unable to meet the needs to provide a clean, safe, healthy home environment	154	Hours	$12.22
Respite Care	Services provided temporarily or periodically in the absence of usual caregiver	363	Hours	$19.07
Adult Day Services	Community-based group programs for adults with impairments; meals and/or nutritious snacks are required; three levels (basic, enhanced, intensive)	110	Days	$67.90
Environmental Modifications	Physical adaptations to the home necessary to ensure the health, welfare, and safety of the recipient and to enable the individual to function with greater independence, and without which, the individual would require institutionalization	1	Unit	$3,908.72
Transportation	Transportation provided to enable recipients to access to waiver and other community services, activities, and resources, specified in the plan of care	1	Month	$150.00
Specialized Medical Equipment	Devices, controls, or appliances which enable the recipient to increase ability to perform ADLs or to perceive control, or communicate with the environment in which they live; also includes items necessary for life support, ancillary supplies, and non-durable medical equipment not available under the Medicaid state plan	1	Unit	$2,317.94
Personal Emergency Response Systems	Electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency	10	Months	$32.77
Attendant Care	Assistance with physical dependency needs	406	Hours	$16.32
Adult Foster Care	Personal care and services, homemaker, chore, attendant care, companion services, medication oversight provided in a licensed private home by a principal care provider who lives in the home; recipients reside in the home	303	Days	$34.89
Assisted Living	Personal care and services, homemaker, chore, attendant care, companion services, medication oversight, therapeutic social and recreation programming, provided in a home-like environment in a licensed community care facility, in conjunction with residing in the facility; 24-hour on-site response staff included	303	Days	$44.51
Congregate Care	Services designed to ensure health, safety, and welfare for recipient to live successfully in his/her home or living unit/apartment in senior housing community	303	Days	$29.81

Waiver Service	Definition of Service[1]	Estimated Annual Units Per User	Unit	Reimbursement Rate Per Unit
Home Delivered Meals	Nutritionally balanced meal; up to two meals per day	237	Meals	$4.78
Nutritional Supplements	Nutritional (dietary) supplements, including liquid supplements, to maintain recipients' health in order to remain in community-based setting	10	Months	$102.00
Pest Control Services	Services designed to prevent, suppress, or eradicate pests	5	Units	$153.00
Community Transition Services	One-time set-up expenses for transition from institutional care to home; subsequent moves not reimbursable	1	Unit	$1,000.00

[1] Complete definitions of waiver services located in Appendix XX.

Source: CMS, Renewal Waiver Application.

C. Expenditures and Cost Containment Efforts

In FY2003 the A&D HCBS waiver accounted for nine percent of the state's total spending on HCBS waiver programs, compared to the national average of 18 percent for A&D waivers. Total expenditures for the Indiana A&D waiver were $27.1 million in FY2003, an increase of 27.8 percent from FY2002. The annual compound rate of growth for Indiana's A&D waiver has been 17 percent between 1998 and 2003, higher than the national average of 15.8 percent for A&D waivers over the same period. However, among the A&D waivers in the U.S. that have operated continuously between FY1998 and FY2003, the average annual expenditure in FY2003 was $69.9 million, much higher than Indiana's expenditures. Total U.S. spending on waivers for HCBS for A&D populations was $3.3 billion in FY2003, accounting for 18.0 percent of all HCBS waiver expenditures.[44]

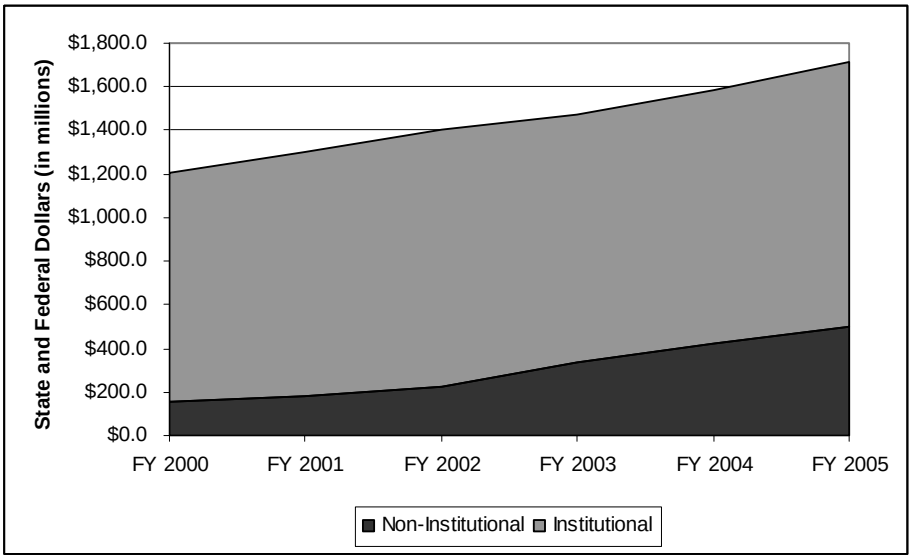
The average cost per recipient per month for Indiana's A&D Waiver was $644 in FY2002, or $7,728 annually, while the nursing facility case mix average rate was $36,749 for the year. Caring for the person in the home and community is considered less costly than care in a nursing facility. However, comparability of nursing home and HCBS populations is often questioned due to concern that waiver participants have less intensive support needs than those in the nursing home.[45] In comparison, a total of $34.3 million was expended on CHOICE in FY2002, down from $38.8 million in FY2001.

To date, Indiana's key LTC cost containment strategies have focused on changes in nursing home payment methodologies as well as HCBS expansions coupled with strategies to reduce nursing home utilization. Waiver cost containment has primarily relied on enrollment caps and low provider rates. The State has forecasted additional significant increases in Medicaid HCBS waiver spending in FY2004. See ***Figure 6*** below for trends in Indiana's LTC expenditures.

[44] Steve Eiken, S., Burwell, B., & Schaefer, M. "Medicaid HCBS Waiver Expenditures, FY1998 through FY2003," May 25, 2004, http://www.hcbs.org/moreInfo.php/state/154/ofs/10/doc/714/Medicaid_HCBS_Waiver_Expenditures_-_FY_2003 and Lewin calculations from the data.

[45] Indiana Family and Social Services Administration, "Statewide IN-Home Services 2002 Annual Report, July 1, 2001 – June 30, 2002."

Figure 6. Indiana Medicaid Long Term Care Expenditure Trends Actual and Projected, Fiscal Years 2000-2005



Source: Lewin calculations from State of Indiana Office of Medicaid Policy and Planning, *Budget Analysis Report for Fiscal Years 2002 Through 2005*, December 19, 2002 (prepared by Milliman USA, Inc. and updated January 29, 2004).

D. CHOICE and the Aged and Disabled Waiver

In addition to acting as the entry point for people applying for the Aged & Disabled HCBS waiver, BAIHS administers the Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) program. CHOICE was established during the 1987 Indiana legislative session, and after starting as a pilot program and growing through several expansions, the program began offering services in all Indiana counties in 1992. CHOICE is a unique state general fund program that provides HCBS to all Indiana residents with disabilities or of advanced age. CHOICE receives positive reviews for providing a variety of home and community-based services and consumer choice to maintain the independence of the individual.[46]

Eligibility rules differ between the A&D waiver and CHOICE. While individuals served by the waiver must be ages 65 and older or disabled and meet the level of care standard for facility care, CHOICE participants must be over age 60 and/or have a disability and must have an impairment that places the person at risk of losing his/her independence, defined as being unable to perform two or more activities of daily living (ADLs) as determined through the use of the Long Term Care Services Eligibility Screen. Because of this requirement, compared to the functional test for HCBS waiver and institutional services, many people in CHOICE have less intense service needs.

CHOICE has no financial eligibility requirements, but it does have a cost sharing requirement for all participants except those who are Medicaid eligible. Services are provided at no charge

[46] FSSA, "Statewide IN-Home Services 2002 Annual Report, July 1, 2001 – June 30, 2002."

for beneficiaries with countable incomes at or below 150 percent of the federal poverty level (FPL); assistance is then reduced as income increases and phases out above 350 percent of the FPL.[47] This contrasts with the A&D waiver, for which recipients must be income eligible and must meet the 300 percent of SSI requirement with spend-down.

In SFY2003, 2,333 CHOICE participants were also eligible for Medicaid. These individuals mostly received LTC services through CHOICE and acute care services through Medicaid. FSSA reviews CHOICE program data to identify individuals who could be converted to Medicaid and, as slots become available, the A&D waiver. As noted earlier, once a consumer becomes eligible for waiver services, he/she may no longer use CHOICE.

It also is important to note that many CHOICE providers are also A&D waiver providers. In fact, FSSA recently began requiring that CHOICE providers must also become waiver providers. In related matter, as discussed later, CHOICE rates, set locally, are considerably higher than A&D waiver rates which have not been increased in several years. However, the State has increased rates in other waiver programs.

[47] Tilly, J. & Goldenson, S.M. The Urban Institute and The Lewin Group, "Home and Community-Based Services for Older People and Younger Adults with Physical Disabilities in Indiana: Final Report," February 26, 2001.

IV. OVERVIEW OF HCBS EXPANSION

As Indiana grows its HCBS programs and considers additional changes in its LTC support system, consumers, state officials, and policymakers should consider the experiences of other states that have taken similar steps, especially those with analogous LTC systems (i.e., a highly locally-operated single point of entry network). It also is important to examine broader LTC systemic components in light of HCBS expansion.

A. Long Term Care Rebalancing Considerations

Early research regarding the cost-effectiveness of HCBS indicated that program expansions resulted in increased spending and that, specifically, "small reductions in (nursing home (NH) costs for some are more than offset by the increased costs of providing expanded community services to others, who even without expanded services, would not enter nursing homes."[48] However, these studies were based on data collected in the early 1980s when the availability and nature of services (high tech and alternative residential) able to be delivered in the community differed substantially from today. Subsequent analyses suggested that specific management techniques -- targeting and building in cost-control mechanisms for services, including low average benefit levels, and a strong emphasis on services provided in alternative residential facilities -- could result in HCBS expansions that do not increase overall LTC spending.[49] Below are highlighted some important considerations related to HCBS growth and cost effectiveness.

1. Managing Institutional Costs

Without complementary changes in institutional services, research suggests that expanding HCBS programs is also more likely to increase rather than decrease total LTC costs.[50] Common efforts to reduce institutional use while growing HCBS programs include:

- *Certificate of Need Programs* – In states with this requirement, providers must document that there is demand for their services, submit this information to the state and await state approval before expanding or adding bed capacity.

- *Occupancy Rate Changes* – Many states have implemented occupancy rate requirements under which nursing home providers are no longer reimbursed for administrative and other overhead costs related to maintaining unoccupied beds.

Research in three states, Colorado, Oregon, and Washington, has provided encouraging information on the cost-effectiveness of HCBS when coupled with institutional cost control measures including closure of nursing home beds as HCBS grows and steps to target services to those most at risk of nursing home placement (see below). Recently, CMS released a letter to

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[48] Kemper, Applebaum, & Harrigan (1987). "Community Care Demonstrations: What Have We Learned?" *Health Care Financing Review,* 8(4): 87-100.

[49] Doty, P. (June, 2000). "Cost-Effectiveness of Home and Community-Based Long-Term Care Services," USHHS/ASPE Office of Disability, Aging and Long-Term Care Policy, http://aspe.hhs.gov/daltcp/reports/costeff.htm.

[50] "Medicaid Cost Containment, A Legislator's Tool Kit," National Conference of State Legislatures, March 2002.

state Medicaid directors outlining important strategies related to HCBS cost effectiveness and the importance of transferring institutional dollars to HCBS programs to ensure that "money follows the person" (see ***Appendix B***). A study of Colorado's Elderly, Blind and Disabled waiver found considerable savings for the State and highlighted a drop in the proportion of Colorado's population in nursing homes that was faster than the national average rate of decline.[51] Washington State reports $23 million in FY2003 savings related to the provision of HCBS in place of nursing facility services.

Indiana has made substantial strides in HCBS growth, and OMPP recently implemented a minimum occupancy standard. In July 2003, the standard increased from 65 percent to 85 percent; the current statewide nursing home average occupancy rate is 84.7 percent. By requiring nursing homes to maintain a minimum occupancy standard, fewer beds will remain unused. Reducing the number of unused beds can reduce the per diem costs of nursing home care and thereby reduce total Medicaid costs. Additionally, Indiana no longer reimburses nursing homes with occupancy levels below 90 percent for days residents are not present (i.e., bed hold day payments). These steps have helped facilitate the delicensing of nearly 5,000 nursing home beds statewide, approximately 1,700 of which were due to facility closures. However, Lewin analysis under a separate project estimated that excess nursing home capacity still remains.[52]

An additional area of work aimed at reducing nursing home use is providing information and counseling to consumers and families at points where LTC decisions are made. These points include discharge from a hospital following a health crisis when nursing home services might be considered or decline in a family caregiver's capacity to support a relative. Programs targeted to steer people away from nursing home admission are called nursing home diversion programs. Other efforts focus on returning nursing home residents to their homes and communities; these are called nursing home transition projects.

States face significant obstacles in diverting and transitioning individuals out of nursing facilities and into HCBS settings. Throughout the LTC system, there exists an institutional bias toward placing people in nursing facilities rather than in HCBS settings. The bias begins with consumers and families, who likely have some familiarity with nursing homes and the care they provide, but know little about HCBS and the range of options they offer. Without an adequate source of information to help them understand their options, individuals with LTC needs are more likely to turn to nursing home care, even if another setting may be more appropriate or preferable. The institutional bias also is present in hospitals, the nation's major source of LTC referrals, among doctors, rehabilitation specialists, and hospital discharge staff.

a. Diversion from Nursing Facility Services

To date, most states have some form of nursing home diversion program; the most well known are programs in Colorado, Oregon, and Washington State. These early implementers and states currently developing nursing home diversion programs face an array of challenges including:

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[51] Wiener, J. & Stevenson, D. "Long-Term Care for the Elderly: Profiles of Thirteen States," The Urban Institute, August 1998, p. 25.

[52] The Lewin Group, "Opportunities and Options for Indiana Medicaid," September 2004.

- Nursing homes are more visible in the community and typically have staff that can help consumers and families with the Medicaid application. HCBS providers and intake sites are not as visible or commonly recognized, and most do not have staff available to help with Medicaid applications and must refer consumers/families to local Medicaid offices or local disability program offices;
- Nursing homes typically have more operating capital than HCBS providers and can absorb service costs while a new resident's Medicaid application is processed; and
- Nursing home services are a State Medicaid Plan benefit and are therefore an entitlement for all eligible beneficiaries. HCBS waiver services are not an entitlement and many states have waiting lists. Additionally, some HCBS services, such as Personal Assistance Services (PAS), are an entitlement but states sometimes limit the number of hours available or are unable to secure adequate workers to meet program demands.

In addition to these challenges, states also must identify funding sources for diversion programs, develop administrative infrastructure for program operations, and define the program goals and outcomes including, most importantly, defining a successful diversion. Related to the latter point, states also must develop strategies to measure diversion program performance and impacts.

b. Transitioning from Nursing Facility Services

Once individuals stay in nursing facilities for 30-60 days, it becomes highly unlikely that they will leave, even if their needs change. Nursing home residents typically disburse resources and assets, such as a house and furnishings, cars, and savings, in order to finance even a moderate stay in a nursing facility. To return to the community, most of these resources must be replaced. Additionally, individuals and their families may become comfortable with the nursing home setting.

Nursing home transition programs must develop methods of identifying potential candidates, develop administrative and operational infrastructure for the program including staff to serve as transition coordinators, identify funds to cover upfront moving costs (i.e., rent and utility deposits), and develop needed community-based services and related supports such as income assistance, transportation, and medical care providers. State experiences indicate that individuals who transition have not typically been long term residents, have some informal or natural supports available in the community, and do not have dementia.[53]

As these projects moved from concept to practice, States quickly learned that diversion and transition staff had to be available at key junctures. For diversion, these include: a) the point of hospital discharge; and b) points of care crisis for families. For transition services, transition outreach/coordination staff must be available in nursing facilities and other facilities to interact with individuals and families in order to screen for strong transition candidates, explain options to individuals and families who are good candidates, and to coordinate the complex transition process.

[53] Presentation by Steve Eiken, Thomson MEDSTAT, entitled "Lessons from the 1998-2000 Nursing Home Transition Grants," dated October 27, 2003.

For several years, Indiana has been operating both diversion and transition programs. In Indiana, after working with hospitals to identify patients likely to enter nursing homes, AAA case managers provide information about home and community-based services to hospital patients who may be admitted to nursing homes after leaving the hospital. Through this program, 316 people accessed home and community-based services in 2002.[54] For state fiscal years 2003–2005, the State has allocated 1,516 HCBS waiver slots to support nursing home diversions.

Indiana targets individuals specifically in nursing homes that are closing, focusing on residents that will need to find a new provider for their LTC. The State has created Senior Care Teams for this effort, which includes case managers or staff from the local nursing home ombudsman, local AAA, the Department of Health, the State Medicaid agency, and the HCBS waiver operating agency. After a nursing facility gives its 30-day closure notice, Senior Care Teams are assigned to affected residents to discuss with them all their rights and options, and to help them find a new provider, whether it is community-based or another nursing facility. As of July 2004, the state supported the transition of 172 individuals back into the community. Indiana finances both transition and diversion efforts with HCBS waiver-financed case management service dollars and state general fund dollars.

2. "Woodwork Effect"

Advocates, policymakers, and researchers have long been interested in the possibility of providing individuals with disabilities the opportunity to receive needed services in the community rather than entering nursing homes. Theoretically, such a shift in the setting of care would result in a higher quality of life for Medicaid LTC recipients and savings for Medicaid programs, as home and community-based services generally are less costly than nursing home care.

Traditionally, the argument against such a policy has been that the number of eligible persons signing up to receive HCBS would be so large that it would consume any program savings that might have resulted from fewer nursing home admissions. This scenario has been dubbed the "woodwork effect" after the observation that when a program becomes attractive, as when HCBS are as available as nursing facility services, unanticipated numbers of eligible participants will "come out of the woodwork" to request services. States have employed a variety of strategies to address the woodwork effect.

Literature and research on the woodwork effect consistently has shown that HCBS expansion yields increases in LTC spending. Newly eligible persons demanding services tend to dominate the HCBS for nursing home substitution effect because very few nursing home admissions are deferred by receipt of HCBS. In order to control LTC spending growth or achieve savings while expanding HCBS, states must:

- Restrict services to only those at a high risk of nursing home use;[55]
- Institute rigorous controls on or reductions in nursing home spending;

[54] Crisp, S. et al., Medstat, "Money Follows the Person and Balancing Long-Term Care Systems: State Examples, 2003."

[55] Vertrees, Manton, and Adler (1989). "Cost Effectiveness of HCBC," *Health Care Financing Review.* (10)4, pages 65-77.

- Carefully craft service packages to ensure comparability between institutional and HCBS settings in order to ensure prevention or delay of nursing home placement;[56] and
- Control HCBS spending.

An additional concern to policymakers directly related to the woodwork effect has been whether public provision of HCBS will "crowd out" private, informal care giving, a critical component of our national LTC array, as Arno et al. showed in his 1997 study (see page 11 of this report). The sizeable literature on this topic indicates that the crowding out that does occur is likely to be quite minor.[57] In *Section V* of this report, Lewin models the potential impact of the woodwork effect on the SEA 493 financial eligibility changes.

3. Intake and Waiting List Management

Above are discussed the details of A&D waiver intake, current waiting list management and planned changes in the list and related waiver slot allocation. The key elements in this area for states to consider in terms of HCBS expansion and cost effectiveness are strategies that effectively target individuals who are most at risk of institutional placement, as well as the administrative infrastructure to provide swift and tailored supports to these individuals and their families.

B. Provider Capacity

Provider recruitment and retention for HCBS programs is a national challenge for existing community-based programs; for states hoping to expand HCBS, provider capacity is a daunting task. Major issues include low reimbursement rates, difficultly obtaining and retaining direct support workers, and onerous licensure and certification requirements. There is a wealth of literature on provider recruitment and retention especially describing methods to increase rural provider participation and the need to increase reimbursement rates to providers under Medicaid. Discussed below are steps some states have taken to increase provider capacity.

a. Reducing paperwork during provider application process

In Washington State, for example, all home care agencies are initially licensed by the Washington Department of Health, but annual monitoring is conducted by the AAAs and the results are sent to the Department of Health. The State has worked to streamline licensure requirements so that the process involves less paperwork for providers.[58] However, Washington has set additional requirements that both agency providers and independent providers pass a criminal background check and also complete a state-developed standard caregiver training.

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[56] Ibid.

[57] Hanley, Weiner, and Harris (1991). "Will paid home care erode informal support?," *Journal of Health Politics, Policy, and Law*. 16(3), pages 507-521.

[58] Wiener, J. and Lutzky, S. (2001). "Home and Community-Based Services for Older People and Younger Persons with Physical Disabilities in Washington. " Prepared for the Centers for Medicare and Medicaid Services.

b. *Using automated payment and billing mechanisms*

In Texas, all LTC waiver and state-funded provider claims are processed and managed across a single system. Providers are given the option to submit claims either by paper or electronically through a Windows-based software, called TDHConnect, or through a third-party software that meets system requirements. TDHConnect is an expansion of the system previously developed for Medicaid acute care providers. Because the software is compatible, providers who serve both LTC and acute care consumers can submit claims using just one system—the Claims Management System (CMS). The goals for using CMS are to:

- Present a more accurate way for providers to be reimbursed for the services provided;
- Eliminate duplicate functions;
- Provide flexibility for future modifications;
- Improve community relations with all providers;
- Lower the administrative costs associated with processing claims; and
- Replace divergent systems with a common payment and tracking system.

A contracted insurance company edits the claims to verify the validity of the information on the claim and that it meets the requirements for the program being billed. A "Remittance & Status" report notifies providers if the claim is paid, denied, or in process. The insurance company is not involved in actual service authorization and does not act as a contract authorizing entity. A help desk is available for provider questions. Indiana currently uses a sophisticated electronic provider billing and claims payment system for HCBS waiver providers operated by EDS under contract with OMPP.

c. *Promoting equitable provider rates across programs*

Components of Minnesota's LTC reform initiative have involved identifying layers of paperwork and documentation that are overwhelming and ineffective for providers as well as examining geographic disparities between different programs with similar services. They also identified the need to examine the extent to which the current reimbursement structure supports consumer-directed care. They identified the need to modify disparities in home and community-based provider rates to promote a more equitable and high-quality service system.[59]

d. *Linking vendor payment levels to performance measures*

Several states are promoting quality care by creating incentives for providers to meet consumers' needs as demonstrated through measurable outcomes. The Georgia Governor's Blue Ribbon Task Force on Home and Community-Based Services recommended that provider participation and reimbursement in the home and community-based service system be based on

[59] "Reshaping Long Term Care in Minnesota," State of Minnesota Long-Term Care Task Force: Final Report, January 2001.

performance measures.[60] Similarly, Rhode Island passed legislation that ties home care reimbursement rates to increased performance by providers and staff.[61]

Section V summarizes some of the challenges that A&D waiver service providers note that would hamper their capacity to support waiver growth.

C. State Experiences

To provide Indiana with information on how other State's expanded HCBS, The Lewin Group examined three Medicaid waiver programs for older adults and persons with disabilities. Lewin focused on several key components related to HCBS expansion -- consumer enrollment and provider recruitment and retention.. The selection of Colorado, Washington, and Wisconsin was based on discussions with national experts, a focused literature review, and insight from Lewin experiences with LTC systems in many states. These States have had waivers serving persons with physical disabilities and persons of advanced age for 11, 19, and 15 years, respectively. The Family Care pilot program in Wisconsin was enacted in 1999 under Wisconsin Act 9 and its concurrent Section 1915(b)/(c) waiver was approved in 2001. Key findings for Indiana from Lewin's review of these programs include:

- Reallocation of Medicaid funds and substantial efforts to shift LTC dollars from institutional to home and community-based settings is essential to slow LTC cost growth or achieve savings;
- Development of controls to manage the growth of home and community-based services and the impact on the provision of services;
- Innovations with strong, locally-based systems including single points of entry systems (SEP), like Indiana, through which level of care and financial eligibility is determined, LTC information and assistance is provided to consumers, and consumers are assisted with applications and communicated with about their application and enrollment status; and
- Implementation of a variety of strategies to streamline provider enrollment, including simplifying the application process, establishing a recognizable point-of-contact, and tailoring provider requirements.

Finally, all three states began HCBS expansion and concurrent efforts to reduce institutional expenditures in the late 1980s and early 1990s. Systems changes and paradigm shifts of this magnitude have taken several years to achieve in a safe and sustainable manner. For more detail on Colorado, Washington, and Wisconsin's waivers, see ***Appendix C***.

[60] "Governor's Blue Ribbon Task Force on Home and Community-Based Services: Final Report," 2001, Available at: http://www.ga-ddcouncil.org/blueribbon/final.htm.

[61] "State Long Term Care Workforce Initiatives," 2002 Available at: http://www.nga.org/cda/files/STATELTCINITIATIVES.pdf.

V. IMPLEMENTATION ANALYSIS

To assess the impact of expanding the Indiana A&D waiver, The Lewin Group took a three-pronged approach. First, Lewin gathered information from individuals involved in day to day waiver operations on the program's capacity to absorb significant growth. Lewin interviewed ten state staff responsible for administration and oversight of the waiver program regarding current waiver capacity, as well as the necessary steps to accommodate adding a significant number of slots to the waiver.

Second, Lewin transmitted a questionnaire on HCBS capacity to accommodate waiver growth to all AAAs, a list of ten HCBS service providers, and advocacy organizations. Two AAAs responded as well as the Indiana Association of AAAs; seven providers responded. Lewin used this information to develop an estimated cost related to developing needed administrative infrastructure to support A&D waiver growth. Finally, Lewin completed a series of quantitative analyses aimed at estimating costs associated with increasing the waiver income test from 100 percent of SSI to 300 percent of SSI while also increasing the number of available waiver slots to a level that would meet demand. Lewin also modeled decreased revenue.

A. Stakeholder Assessment of HCBS Waiver Expansion in Indiana

1. State

Both DDARS and OMPP staff were interviewed on several specific areas, including: a) quality assurance operations; b) single point of entry (i.e., AAA and Independent Case Manager) functions; c) provider recruitment, enrollment, and retention strategies; d) billing and claims payment; and e) waiver administration and policy. Among the ten state staff interviewed for this project, key areas of concern related to supporting significant waiver expansion include:

- In the quality assurance arena, the State is currently struggling to hire interviewers and other personnel under a new CMS quality grant for activities described above. If the waiver population grew, considerably more QA staff would be needed, and difficulty is expected in hiring these additional personnel.
- Currently the Hearing and Appeals process takes 30 days assuming all materials are provided with the case file. Currently there is a backlog of cases. Staff expressed concern about capacity to handle additional growth.
- Growth in the number of waiver residential settings presents challenges for licensing residential services providers under the waiver. Currently there are no regulations for Personal Care Assistance (PCA) homes with less than four beds and no rules for Assisted Living; these settings currently are licensed as Department of Health residential facilities. FSSA would have to build capacity to review, license, and monitor new residential settings.
- State staff also highlighted several provider concerns:
    - Currently, OMPP requires waiver providers to work with EDS to become enrolled Medicaid providers. Meanwhile, DDARS has two provider certification specialists

to ensure CMS requirements for the waiver. Staff noted the need to eliminate the duplication both to reduce FSSA's burden associated with the possibility of more providers applying and to speed up the review process of new providers as waiver service demand grows.

  - Waiver rates have not been increased in four years and are much lower than CHOICE rates. While FSSA is now instituting a requirement that CHOICE providers must also be waiver providers, challenges may still arise as AAAs work with providers to serve waiver clients who may represent an operating loss.

- Independent Case Managers (ICMs) also have presented several challenges:

  - They create confusion regarding the AAA functions as single points of entry, especially between aging and disabled services and services for persons with developmental disabilities;
  - State staff indicated the ICMs seemed less likely to correctly use INsite;
  - ICMs sometimes send waiver financial eligibility packets to local DFC offices rather than the waiver Client Eligibility Unit (CEU).
  - Some ICMs have strong relationships with providers; this raises concerns about consumer choice.

Conversely, State staff also felt that several current practices or strategies under development would serve as a good foundation for waiver expansion:

- Development of the Waiver Services Unit will help increase waiver staff capacity, increase data sharing across waivers, enhance cross-waiver planning, and streamline waiver operations;
- Changes in the AAA contract and reallocating responsibilities between the AAAs and the state will enhance statewide planning efforts as well as improve the timeliness of data – especially from INsite;
- Extending quality assurance strategies used in the Developmental Disabilities waiver to the A&D waiver with the CMS Quality Grant funds will provide a much stronger quality approach; and
- Development of the relational database on regional provider capacity and related provider recruitment strategies used under other waivers will support expansion of the A&D waiver provider network.

2. Local

Entities providing services through the A&D waiver, including homemaker, respite, transportation, attendant care, assisted living, and other services, were interviewed regarding their experience with the waiver program. AAAs also were interviewed to assess their waiver experiences.

The major issues reported by the providers and AAAs pertained to timeliness of payment and reimbursement rates, provider service hour requirements, provider recruitment, coordination

with other services, state staffing, diversion and transition issues, provider availability, over-regulation, and AAA staffing. Providers and AAAs had the following comments on the current waiver operating environment that would impact their ability to expand their capacity in order to meet the demand associated with waiver expansion:

a. Reimbursement rates and receipt of payments

- There has been no increase in reimbursement rates for five years, and the last increase was 1.4 percent.[62]
- The rates include no overhead and providers find it difficult to pay workers and pay transportation costs. This is very difficult in rural areas.
- Reimbursement levels limit providers' ability to hire quality staff.
- If reimbursement levels remained constant, many providers would be operating at a loss, no matter how streamlined they became. Clients would have to be turned away and would go underserved. Some providers are currently not accepting new clients, due to the low reimbursement rates.
- Some providers may also become increasingly reliant on outside sources, such as fundraising, to supplement the shortfall.
- The time between submission of bills and receipt of payments often is too long. Payment delays make it difficult for providers to meet their financial obligations.

b. Providers requiring minimum number of service hours

- This is becoming more common in some areas, and the pool of available providers is dwindling.
- If rates were addressed by the state, the provider pool might expand. If not, many providers will no longer provide Medicaid Waiver services.

c. Provider recruitment and availability

- There are not too many strategies available to recruit providers which would offset low reimbursement rates that do not cover their costs.
- Even when AAAs recruit providers, they must apply to the state to become Waiver providers. The lack of a local contact is a deterrent.
- The current system has proven to be ineffective in recruiting and maintaining providers.
- If additional providers were to become available and the number of waiver recipients were to increase, AAAs would need to increase the number of staff working with these individuals and providers.

[62] See Section III for more information on CHOICE and A&D waiver rates.

d. Coordination with other care and services

- If the client is receiving Medicare services from an agency that will not provide Waiver services, it makes it difficult to convince another provider to go in and provide the Waiver services.
- There is a lack of cooperation from hospitals and physicians in diversion and transition.,

e. State staffing

- Additional state staff would be needed to ensure timely approval of services and avoid a backlog of clients who meet criteria.
- The time from submitting an application to getting approval and beginning provision of services often is too long.

f. Diversion and transition issues

- Budgets must be approved by the state; the state will not approve the budget until the day the client comes home; services are needed that day or prior to that day, and the providers cannot/will not provide them without approval.
- As mentioned above, there is a lack of cooperation from hospitals and physicians in this area. It would have been helpful to have the state validate to these providers that this is an important initiative.

g. Over-regulation

- There is a lack of coordination between requirements for licensure and the Waiver qualifications.
- The various requirements from regulatory agencies and auditing systems are inconsistent and sometimes contradictory.

h. AAA issues

- The administrative infrastructure is in place for expansion, but additional case managers would be needed to handle additional recipients.

B. Estimated Enrollment and Service Costs

1. Overview

FSSA asked Lewin to study the impact of increasing the income limit for eligibility as well as the addition of new service "slots" under the A&D waiver. Lewin also examined whether the costs associated with these expansions could be paid for by transitioning individuals from nursing homes into the A&D waiver, which is less costly than nursing homes. Finally, Lewin studied the impact of eliminating waiver participants' cost sharing responsibilities under the A&D waiver. Before discussing the specifics of our analysis it is first important to understand a few key elements regarding HCBS waivers.

2. Managing Waiver Programs

Federal law requires states to ensure that its HCBS program is cost effective. Cost effectiveness means that the overall per capita cost to state Medicaid programs for providing HCBS services is less than or equal to costs in a nursing home or other institutional setting.

As noted earlier, HCBS services are not an entitlement and states may limit the number of participants either by defining a number of "slots" based on the maximum allowable waiver cost that will maintain cost effectiveness or by budgeting a certain amount of dollars for the waiver and "backing in" to individual costs. Reading the following analysis, it is critical to understand that waiver services must cost less than the institutional alternative.

3. HCBS Modification Implications

In this section, Lewin provides estimates of the fiscal impacts of a policy change that would extend full Medicaid A&D Waiver coverage to persons up to 300 percent of SSI who have three or more ADL limitations. The components of this estimate include:

- Quantifying the claims cost differential between a person being enrolled in the Medicaid Waiver program and being an institutionalized Medicaid recipient.
- Estimating the size of the population that would be eligible for Medicaid Waiver coverage with no spend-down required.
- Quantifying the existing "take-up" rate among persons for whom Medicaid Waiver coverage is provided with no spend-down requirement, as well as the "take-up" rate among persons enrolled in the Waiver at various income cohorts where spend-down cost-sharing is currently required.
- Projecting Waiver program costs through FY2015 in the absence of modifying existing eligibility policies.
- Estimating the Waiver "take-up" rate of eligible persons with incomes between 100 percent and 300 percent of SSI if the coverage were to become free (no spend-down).
- Quantifying the loss of spend-down funds paid by existing Waiver enrollees whose incomes are between 100-300 percent of SSI.
- Quantifying the costs the additional enrollees would generate, versus if they were to remain outside of Medicaid.
- Estimating the offsetting savings that can occur by transitioning existing institutionalized persons out of nursing homes as a result of the expanded Waiver coverage program.
- Estimating the offsetting savings that can occur through the new Waiver enrollees remaining in the community setting longer and delaying or altogether avoiding their becoming institutionalized Medicaid recipients.
- Estimating savings in state funds that can occur through existing CHOICE Program enrollees enrolling in the expanded Waiver program.

- Each of these component analyses are described in detail in the remainder of this section, concluding with a summary of the key findings.

In the following pages, we describe each of the components in detail as well as the modeling outputs.

a. Quantify the claims cost differential between a person being enrolled in the Medicaid Waiver program and being an institutionalized Medicaid recipient.

The Lewin Group obtained Medicaid claims, eligibility and income data for Indiana's aged and disabled recipient population. Costs were quantified for services incurred during state fiscal year 2003, the most recent year in which data were available (and for which claims lag issues would create only a very minor distortion). SFY2003 extends from July 2002 through June 2003.

Costs for institutionalized and for A&D Waiver populations are summarized in ***Table 9***. Total claims costs and covered months were used to translate the figures into costs per member per month (PMPM).

Table 9. FY2003 PMPM Indiana Medicaid Claims Cost

Service Category	AD Waiver Enrollees	Institutionalized Enrollees	Adjusted Inst. Enrollees
Nursing Home	$0	$2,497	$2,122
AD Waiver	$649	$0	$0
Inpatient	$99	$107	$107
Pharmacy*	$327	$297	$297
Durable Med. Equip.	$105	$18	$18
All Other Medicaid Services (physician, home health, etc.)	$550	$142	$142
Total	**$1,730**	**$3,060**	**$2,685**
PMPM Cost Differential			**$955**

* Observed pharmacy claims cost reduced by 15 percent to factor in rebates and by another 10 percent to factor in the impact to states of the Medicare prescriptions drug benefit.

For purposes of identifying the PMPM cost differential of keeping a supporting an individual in the community (via the A&D Waiver) versus institutionalization, we made one adjustment. Lewin arrayed each institutionalized individual's nursing home claims cost as of a selected month. The average cost of *all* institutionalized persons ($2,497 as shown in the middle column of ***Table 9)*** includes the highest acuity nursing home residents for whom no realistic community-based alternative exists. The $2,122 PMPM cost in the "Adjusted Inst. Enrollees" column reflects the average monthly nursing home claims cost among institutionalized persons who had relatively lower acuity (defined as persons with monthly nursing home claims costs of $1,500 to $2,500).

Costs have been projected forward through FY2015 at an assumed PMPM annual rate of increase of 5 percent. Thus, the $955 differential as of FY2003 widens to more than $1,700 PMPM in FY2015. Another means of assessing the cost differential is that the Waiver population's PMPM costs are approximately two-thirds of those institutionalized recipients who are deemed to be of similar acuity to the Waiver population.

b. Estimating the size of the population that would be eligible for Medicaid Waiver coverage with no spend-down required.

The Lewin Group produced estimates of the number of people in Indiana with disabilities by age group, income, and detailed level of functional disability. Several sources of data were statistically combined to generate these estimates, because no single data source contains the necessary level of detail necessary. Specifically, while rich information about demographic characteristics and general disability exist at the state level, detailed disability data only exist at the national level. Two sources of data were used in developing the estimates for the model:

- **2000 Census Public Use Microdata Sample (PUMS)** -- The PUMS data include actual responses to the 2000 Census questionnaire for a 5 percent sample of the entire U.S. population. The PUMS data contain responses for three broad questions about disability for all persons aged 5 and older, indicating whether the individual has chronic difficulty with each of the following: personal care (e.g., bathing, dressing); going outside the home alone (e.g., shopping); and working at a job or business. Because the sample is so large, the PUMS can produce solid estimates at the state (and in some cases county) level.

- **1996 panel of the Survey of Income and Program Participation (SIPP)** -- A nationally representative longitudinal survey of the community-dwelling population, the SIPP provides greater detail about disability by asking many more questions than the PUMS decennial census instrument. The Indiana model required information about functional limitations, defined as requiring the help of another person in order to perform any of a number of Activities of Daily Living (ADLs)[63] or Instrumental Activities of Daily Living (IADLs).[64] The SIPP contains this information, as well as the same general disability measures captured in the PUMS.

In order to generate estimates of the numbers of persons with functional limitations, a statistical matching technique was used to assign each individual in our PUMS data set, a set of probabilities of having different functional limitations, conditional on the individual's age and his or her answers to the PUMS disability questions. In other words, the general disability information, which is found in both files, was used to link the files together, so that the more detailed disability information from the SIPP could be "borrowed" and assigned to the PUMS.

[63] The six ADLs used in this analysis include bathing, dressing, eating, transferring, using the toilet, and getting around inside the house.

[64] The six IADLs used in this analysis include paying bills, taking medication, using the telephone, getting around outside the house, doing light housework, and preparing meals.

The prevalence of "general" disability among working-age adults was considerably higher in the PUMS data than in the SIPP data. An *ex post* adjustment was therefore made to the numbers of adults with functional disabilities. The numbers were adjusted downward for the adult group to match the national prevalence rates observed in the SIPP and National Health Interview Survey on Disability (NHIS-D), another commonly used source of national disability data.

The model assigned individuals to one of the following mutually exclusive categories:

- Mental Retardation/Developmental Disability (MR/DD)[65]
- 3 ADL limitations
- 2 ADL limitations
- 1 ADL limitation
- IADL(s) only
- No disability

Note that individuals with MR/DD are therefore captured in the first category, regardless of their level of ADL or IADL limitation.

The model excludes individuals residing in institutions, which include nursing facilities, psychiatric inpatient hospitals, and Intermediate Care Facilities (ICF-MRs). In addition, the model's estimates for MR/DD and functional limitations exclude children younger than age six because the functional disability measures used are not appropriate for this age group, and disability data for this group are less reliable.

Disability estimates were projected from 2000 to 2005, 2010, and 2015 assuming that the disability rate with each age group remains constant. Thus, changes in the overall rate of disability are driven entirely by projected changes in the age distribution of the population (e.g., as the population ages, the proportion of people with disabilities increases because older people are more likely to have a disability). The literature is mixed on whether actual age-specific disability rates have been changing in recent years. Some evidence exists that disability among older people is declining, but trends appear to differ by level of functional impairment. Disability rates among working age individuals, on the other hand, are generally thought to be increasing. However, to be conservative, the model assumes no change in disability rates for any age group from 2000 to 2015.

The survey data were tabulated in the following SSI income cohorts: <100 percent SSI, 100-200 percent, 200-300 percent, and 300+ percent of SSI. Lewin staff further broke the 100-300 percent population into 50 percentage point increments, assuming an equal number of persons exist in the two "halves" of each 100 percent bracket. A summary of the population size estimate, by year through FY2007, is shown in ***Table 10***. Figures for the elderly (65+) and non-elderly (16-64) age cohorts are separately shown in ***Table 10***.

[65] Individuals were considered to have MR/DD if they (or a proxy) responded "yes" to questions of whether he or she had mental retardation or "a developmental disability such as autism or cerebral palsy."

Table 10. Non-Institutionalized Population

65+, 3 or More ADLs, SSI

Income Band	2003	2004	2005	2006	2007
< 100% of SSI	1,630	1,658	1,686	1,714	1,741
100-149% of SSI	2,998	3,049	3,100	3,151	3,202
150-199% of SSI	2,998	3,049	3,100	3,151	3,202
200-249% of SSI	2,451	2,493	2,535	2,577	2,618
250-299% of SSI	2,451	2,493	2,535	2,577	2,618
Subtotal, 100-299% of SSI	10,898	11,084	11,270	11,455	11,640

16-64, 3 or More ADLs, SSI

Income Band	2003	2004	2005	2006	2007
< 100% of SSI	3,381	3,409	3,437	3,450	3,463
100-149% of SSI	1,914	1,921	1,928	1,935	1,943
150-199% of SSI	1,914	1,921	1,928	1,935	1,943
200-249% of SSI	1,135	1,139	1,143	1,147	1,151
250-299% of SSI	1,135	1,139	1,143	1,147	1,151
Subtotal, 100-299% of SSI	6,097	6,119	6,141	6,164	6,187

Note that Lewin's population estimate continues to FY2015; ***Table 10*** is cut off at FY2007 for presentation simplicity.

We estimate that roughly 22,000 non-institutionalized persons currently meet the income and 3 ADL restriction eligibility requirements for the Waiver, 17,000 of whom are between 100-300 percent of SSI. Under the proposed policy change, Waiver enrollment for all of these individuals would be available with no spend-down. Under current policy, persons between 100-300 percent of SSI must spend-down each month to the 100 percent SSI level prior to Waiver coverage taking effect. The size of the Waiver-eligible population is projected to grow modestly each year, approaching 26,000 persons in FY2015.

c. Quantifying the existing "take-up" rate among persons for whom Medicaid Waiver coverage is provided with no spend-down, as well as the "take-up" rate among persons enrolled in the Waiver at various income cohorts where spend-down cost-sharing is required.

The size of the target population in the previous step enabled us to quantify the current enrollment "take-up" rates, defined as the percentage of those eligible for the Waiver who are actually enrolled. Working with the income data provided by the State, Lewin identified the current mix of persons by income and by the two age cohorts (48 percent of Waiver enrollees are 65+). The results of these calculations are shown in ***Table 11***. In converting the Waiver population into the SSI cohorts in the bottom half of ***Table 11***, we assume that two-thirds of Waiver enrollees are single due to the expectation that this population has a relatively high

likelihood of never having married, as well as a relatively high likelihood of their spouse being deceased if once married.

Table 11. Income Distribution of 2003 Aged/Disabled Waiver Population

						Estimated 2003 Population		
Avg Monthly Income	#person	#month	estimated single	estimated family	% Dist of Months	16-64	65+	Total
income not reported	19	218						
$1-249	32	365	243	122	1.44%	24	22	46
$250-499	168	1,910	1,273	637	7.53%	126	116	243
$500-749	1504	17015	11,343	5,672	67.12%	1,124	1,037	2,161
$750-999	365	4087	2,725	1,362	16.12%	270	249	519
$1000-1999	177	1912	1,275	637	7.54%	126	117	243
$2000-2999	4	48	32	16	0.19%	3	3	6
$3000-3999	1	12	8	4	0.05%	1	1	2
Subtotal Reporting	2251	25349	16,899	8,450	100%	1,674	1,545	3,219

Conversion of Above Income Cohorts Into Percent of SSI Cohorts

	Monthly Income Cutoffs		Number of Waiver Covered Months			Point in Time Avg	% Distri-bution			
	single	family	single	family	total			16-64	65+	Total
< 100% SSI	$552	$829	7,188	7,111	14,299	1,192	56.4%	944	872	1,816
100 - 149% SSI	$828	$1,244	7,034	840	7,875	656	31.1%	520	480	1,000
150 - 199% SSI	$1,104	$1,658	1,490	319	1,808	151	7.1%	119	110	230
200 - 249% SSI	$1,380	$2,073	382	159	542	45	2.1%	36	33	69
250 - 299% SSI	$1,656	$2,487	382	8	390	33	1.5%	26	24	50
300%+ SSI			422	12	430	36	1.7%	28	26	55
Total			16,899	8,450	25,349	2,112	100.0%	1,674	1,545	3,219

Table 12 compares the Waiver population's demographic composition to that of the overall eligible population to yield FY2003 take-up rates. As one might expect, participation is particularly high among groups who bear little or no cost in enrolling. Across all age groups, the FY2003 take-up rate is estimated to be 36.2 percent among those under 100 percent of SSI for whom the coverage is free.

Participation drops below five percent among income cohorts above 150 percent of SSI, as these persons are required to pay significant monthly cost-sharing to enroll. Take-up rates below five percent are common in health coverage programs that involve both significant public subsidies and significant patient financial contributions. While enrollment appears highly attractive from

an actuarial perspective (e.g., $2,000 PMPM worth of health costs can be purchased for perhaps $500 PMPM), the patients' contribution represents a significant new monthly expense that may not be affordable from their perspective.

Table 12. 2003 Take-Up Rate Estimates

FY03 Estimates	16-64 SSI Population With 3 or More ADLs			65+ SSI Population With 3 or More ADLs			Total SSI Pop. With 3 or More ADLs		
Income Band	Total	Enrolled	Take-Up Rate	Total	Enrolled	Take-Up Rate	Total	Enrolled	Take-Up Rate
< 100% of SSI	3,381	944	27.9%	1,630	872	53.5%	5,011	1,816	36.2%
100-149% of SSI	1,914	520	27.2%	2,998	480	16.0%	4,912	1,000	20.4%
150-199% of SSI	1,914	119	6.2%	2,998	110	3.7%	4,912	230	4.7%
200-249% of SSI	1,135	36	3.2%	2,451	33	1.3%	3,586	69	1.9%
250-299% of SSI	1,135	26	2.3%	2,451	24	1.0%	3,586	50	1.4%
Total	**9,478**	**1,645**	**17.4%**	**12,528**	**1,519**	**12.1%**	**22,006**	**3,164**	**14.4%**
Subtotal, 100-299% of SSI	**6,097**	**701**	**11.5%**	**10,898**	**647**	**5.9%**	**16,995**	**1,348**	**7.9%**

d. Projecting Waiver program costs through FY2015 in the absence of modifying existing eligibility policies.

Our "baseline" estimate of the Waiver program's costs through FY2015 is presented in ***Table 13,*** drawing upon information compiled in the previous steps. These estimates assume a steady upward progression in the take-up rate in the absence of any policy changes, as we envision that the State will, under *any* program design, promote participation in the Waiver program in lieu of placement into an institutionalized setting among persons who are (or become) Medicaid enrollees. We estimate that as of FY2015 the Waiver will have more than 5,000 enrollees and that the program's annual claims costs will reach $200 million. Thus, we assume that the Waiver's enrollment ceiling will steadily increase even if no changes are made to the spend-down requirements.

Based on coverage and income data from the Survey of Income Program Participants (SIPP), we have assumed that half of new Waiver enrollees in the <100 percent of SSI income cohort will not already have Medicaid coverage, with the other half already being on Medicaid but simply converting to the Waiver. Persons who convert are estimated to create added costs only commensurate with the Waiver services (as quantified in Table 9), whereas all claims costs for persons who enroll from outside Medicaid would constitute new costs. Above 100 percent of SSI, all new Waiver enrollment is assumed involve persons not otherwise covered by Medicaid – again based on an assessment of SIPP distributions of the coverage and income distributions of persons with disabilities.

Table 13. Waiver Enrollment & cost Estimate with No Policy Changes, by Year and Income Band

	FY2005	FY2006	FY2007	FY2010	FY2015
Target SSI Group (Uninstitutionalized Persons, 3+ ADL Restrictions)					
< 100% of SSI	5,181	5,266	5,351	5,606	6,425
100-149% of SSI	5,079	5,162	5,246	5,495	6,298
150-199% of SSI	5,079	5,162	5,246	5,495	6,298
200-249% of SSI	3,707	3,768	3,829	4,011	4,597
250-299% of SSI	3,707	3,768	3,829	4,011	4,597
Total	22,754	23,127	23,501	24,620	28,215
Subtotal, 100-299% of SSI	17,573	17,861	18,149	19,014	21,790
Take-Up Rates Estimates					
< 100% of SSI	42.0%	42.4%	42.8%	44.1%	46.4%
100-149% of SSI	25.0%	25.3%	25.5%	26.3%	27.6%
150-199% of SSI	6.0%	6.1%	6.1%	6.3%	6.6%
200-249% of SSI	3.0%	3.0%	3.1%	3.2%	3.3%
250-299% of SSI	1.5%	1.5%	1.5%	1.6%	1.7%
Waiver Enrollment Projections					
< 100% of SSI	2,176	2,234	2,293	2,475	2,981
100-149% of SSI	1,270	1,303	1,338	1,444	1,739
150-199% of SSI	305	313	321	347	417
200-249% of SSI	111	114	117	126	152
250-299% of SSI	56	57	59	63	76
Total	**3,918**	**4,022**	**4,127**	**4,455**	**5,366**
Subtotal, 100-299% of SSI	1,741	1,788	1,835	1,980	2,385
Waiver Population Costs					
PMPM Cost (All Income Bands)	$1,908	$2,003	$2,103	$2,435	$3,107
Total Annual Cost					
< 100% of SSI	$49,814,036	$53,694,160	$57,861,448	$72,299,010	$111,139,985
100-149% of SSI	$29,065,406	$31,329,375	$33,760,897	$42,184,900	$64,847,764
150-199% of SSI	$6,975,698	$7,519,050	$8,102,615	$10,124,376	$15,563,463
200-249% of SSI	$2,545,945	$2,744,254	$2,957,240	$3,695,129	$5,680,252
250-299% of SSI	$1,272,972	$1,372,127	$1,478,620	$1,847,565	$2,840,126
Total	$89,674,057	$96,658,966	$104,160,821	$130,150,980	$200,071,591
Subtotal, 100-299% of SSI	$39,860,021	$42,964,806	$46,299,372	$57,851,970	$88,931,606

Lewin's estimates were tabulated annually through FY2015; years not presented above follow trends shown.

e. Estimating the Waiver "take-up" rate of eligible persons with incomes between 0 percent and 300 percent of SSI if the spend-down requirements were removed and if no wait-list requirements were imposed.

A key component in our cost estimates is the degree to which additional persons in the 100-300 percent income cohorts will come forward and enroll if the spend-down requirement is removed. Similarly, we needed to estimate the enrollment impacts for persons with incomes between 0-300 percent of SSI if the waiting list barrier is eliminated.

The current waiting list includes approximately 2,000 persons, although the State is in the process of creating 600 new Waiver slots. Thus, 1,400 waiting list slots could be impacted by SEA 493. We estimate that half of those on the remaining waiting list (700 persons) have incomes below 100 percent of SSI. This assumption closely parallels the known income mix of persons enrolled in the Waiver. We have estimated that the conversion of wait-list persons to the Waiver will occur over the span of two years. These assumptions about the elimination of the waiting list lead to a take-up rate of 56 percent in FY2006 in the <100 percent SSI income

cohort, which steadily increases to a 60 percent take-up rate in FY2015 due to the expectation that waiver enrollment will be increasingly encouraged under any policy scenario.[66]

Between 100-300 percent of SSI, two factors are occurring simultaneously that increase Waiver program participation. One is the elimination of the waiting list; the other is the removal of the spend-down requirement. One approach to estimating the take-up rate in these higher income cohorts would involve assuming that if participation in the Waiver were made "free" to persons between 100-300 percent of SSI (as is now the case for persons below 100 percent of SSI), the take-up rate among those in the 100-300 percent cohort would eventually match that of the <100 percent cohort. We are inclined to assume a somewhat lower take-up rate in the higher income brackets, due to the fact that persons with higher family incomes are more likely to have resources (both private insurance coverage and family support) that make them less likely to seek program services even when eligible. We have therefore assumed the take-up rates in the higher income brackets to relate to the <100 percent SSI take-up rate on an income-related sliding scale as follows:

Income Cohort	Waiver Take-Up Rate Assumption As Percentage of <100% SSI Take-Up Rate
100 – 149% of SSI	90%
150 – 199% of SSI	80%
200 – 249% of SSI	70%
250 – 299% of SSI	60%

This enrollment increase is gradually modeled beginning in FY2005, such that by FY2007 the take-up rate proportions shown in the above table occurs.

f. Quantifying the loss of spend-down funds paid by existing Waiver enrollees whose incomes are between 100-300 percent of SSI.

If the spend-down requirement is removed, Medicaid costs would immediately increase for *existing* Waiver enrollees between 100-300 percent of SSI who are currently paying for Medicaid covered services each month until their spend-down threshold is reached. ***Table 14*** estimates the value of these spend-down amounts, both in terms of PMPM costs and total annual spending.

[66] The elimination of the waiting list appeared to create as much as a 48 percent increase in waiver enrollment in Wisconsin's Family Care Pilot Program. This study can be accessed on the internet at http://www.legis.state.wi.us/lab/reports/03-0familycare.pdf.

Table 14. Cost of Lost Spend-Down Funds, Existing Waiver Enrollees

	Monthly Spend-Down	Waiver Enrollees	weighted avg spend-down		
< 100% of SSI	$0	1,816	$0		
100-149% of SSI	$161	1,000	$161,050		
150-199% of SSI	$483	230	$110,961		
200-249% of SSI	$805	69	$55,398		
250-299% of SSI	$1,127	50	$55,892		
Total		3,164	$383,301	**$121.15**	pmpm
				$4,599,610	annual $$

Note: A separate calculation of average spend-down amounts was developed based on October 2004 data reports generated by State staff, yielding a closely similar figure to the PMPM amount derived above ($120.97).

Note that while our data analyses did not identify any patterned relationship between income cohorts and PMPM costs among the Waiver population, the ***Table 14*** figures indicate that Medicaid claims costs in FY2003 would be $121 PMPM higher in the Waiver if there were no spend-down. This additional cost is included in our modeling of a program design change where the spend-down requirements would be removed.

g. Quantifying the costs the additional enrollees would generate, versus if they were to remain outside of Medicaid.

The Waiver program's costs under a program design where no spend-down requirements would be imposed for any enrollees (and where the income eligibility cut-off would extend to 300 percent of SSI), and where no wait-list requirement would be imposed, are projected in ***Table 15***. ***Table 16*** then summarizes the enrollment and cost differences of this design change (contrasting the ***Table 15*** figures to those in ***Table 13***).

These estimates indicate that the policy change would increase Waiver enrollment by 1,537 persons in FY2005, growing to 7,049 additional enrollees by FY2010 and 8,490 additional enrollees as of FY2015. The added claims costs associated with the policy change would be $40 million in FY2005, $223 million in FY2010, and $343 million in FY2015.

Table 15. Waiver Population and Cost Estimates Under Removal of Spend-Down and Waiting List Requirements

	FY2005	FY2006	FY2007	FY2010	FY2015
Target SSI Group (Uninstitutionalized Persons, 3+ ADL Restrictions)					
< 100% of SSI	5,181	5,266	5,351	5,606	6,425
100-149% of SSI	5,079	5,162	5,246	5,495	6,298
150-199% of SSI	5,079	5,162	5,246	5,495	6,298
200-249% of SSI	3,707	3,768	3,829	4,011	4,597
250-299% of SSI	3,707	3,768	3,829	4,011	4,597
Total	22,754	23,127	23,501	24,620	28,215
Subtotal, 100-299% of SSI	17,573	17,861	18,149	19,014	21,790
Take-Up Rates Estimates					
< 100% of SSI	48.8%	55.7%	55.4%	57.1%	60.0%
100-149% of SSI	28.0%	46.9%	49.8%	51.3%	54.0%
150-199% of SSI	14.7%	40.3%	44.3%	45.6%	48.0%
200-249% of SSI	11.2%	35.1%	38.8%	39.9%	42.0%
250-299% of SSI	9.4%	30.0%	33.2%	34.2%	36.0%
Waiver Enrollment Projections					
< 100% of SSI	*2,526*	*2,934*	2,963	3,199	3,853
100-149% of SSI	1,424	2,423	2,614	2,822	3,399
150-199% of SSI	744	2,083	2,324	2,508	3,021
200-249% of SSI	414	1,322	1,484	1,602	1,930
250-299% of SSI	347	1,132	1,272	1,373	1,654
Total	**5,455**	**9,894**	**10,658**	**11,504**	**13,856**
Subtotal, 100-299% of SSI	2,929	6,960	7,695	8,305	10,003
Waiver Population Costs					
PMPM Cost, Persons Not Previously On	$2,041	$2,143	$2,250	$2,605	$3,325
PMPM Cost, Persons Previously On Me	$1,325	$1,392	$1,461	$1,691	$2,159
Total Annual Cost					
< 100% of SSI	$57,825,751	$70,518,764	$74,785,149	$93,445,504	$143,646,945
100-149% of SSI	$34,873,341	$62,307,405	$70,596,773	$88,212,047	$135,601,934
150-199% of SSI	$18,227,038	$53,567,028	$62,752,687	$78,410,708	$120,535,052
200-249% of SSI	$10,132,690	$33,998,736	$40,080,373	$50,081,208	$76,986,182
250-299% of SSI	$8,503,248	$29,115,888	$34,354,605	$42,926,750	$65,988,156
Total	$129,562,069	$249,507,820	$282,569,587	$353,076,218	$542,758,269
Subtotal, 100-299% of SSI	$71,736,317	$178,989,057	$207,784,438	$259,630,714	$399,111,324

Lewin's estimates were tabulated annually through FY2015; years not presented above follow trends shown.

Table 16. Waiver Program Enrollment and Cost Impacts Created by Policy Change

	FY2005	FY2006	FY2007	FY2010	FY2015
Enrollment Impact of Policy Change					
< 100% of SSI	350	700	671	724	872
100-149% of SSI	154	1,119	1,277	1,378	1,660
150-199% of SSI	439	1,770	2,003	2,162	2,604
200-249% of SSI	302	1,208	1,367	1,476	1,777
250-299% of SSI	292	1,075	1,214	1,310	1,578
Total	1,537	5,872	6,531	7,049	8,490
Cost Impact of Policy Change					
< 100% of SSI	$7,886,452	$16,561,549	$16,659,096	$20,815,866	$31,998,710
100-149% of SSI	$5,807,935	$30,978,030	$36,835,876	$46,027,147	$70,754,169
150-199% of SSI	$11,251,340	$46,047,978	$54,650,072	$68,286,332	$104,971,589
200-249% of SSI	$7,586,746	$31,254,481	$37,123,132	$46,386,079	$71,305,930
250-299% of SSI	$7,230,276	$27,743,761	$32,875,985	$41,079,185	$63,148,030
Total	$39,888,012	$152,848,854	$178,408,766	$222,925,238	$342,686,678

Lewin's estimates were tabulated annually through FY2015; years not presented above follow trends shown.

h. Estimating the offsetting savings that can occur by transitioning existing institutionalized persons out of nursing homes as a result of the expanded Waiver coverage program.

One possible means of offsetting some of the additional costs identified in the previous section involves discharging currently institutionalized persons whose health status, family support, and financial circumstances make it possible for them to function in the community assuming no required "spend-down."

Whether the existing NH population could have been diverted if their circumstances had been different prior to admission, it will no doubt be difficult to transition large numbers of currently institutionalized persons back into the community. We estimate that a very small proportion of existing long-term care NH residents (at most, 0.5 percent in any given year) will be discharged back to a community-based setting as a result of the SEA 493 change in Waiver policy. Independent of SEA 493, the State is working to enable any institutionalized person who wishes to enroll in the Waiver and can appropriately be transitioned. FSSA has succeeded in discharging almost 200 persons since mid-2004 by aggressively seeking out community-based options when a nursing home closes. We estimate that the policy change could facilitate as many as 150 additional discharges. While these discharges would not come close to offsetting the overall added costs of the Waiver policy change, they are estimated to lower Medicaid costs by more than $1 million per year for several years. The specific estimates are shown in ***Table 17***.

To achieve fiscal neutrality for the Waiver by solely utilizing the transition of existing NH residents, it would be necessary to de-institutionalize roughly half of all existing Medicaid NH residents.

Note that NH discharges are visible events. Thus, if the State wanted to implement a policy change that would be assured of achieving fiscal breakeven, it could create a waiver enrollment system explicitly tied to NH discharges. The PMPM cost estimates herein indicate that for every two persons discharged from a NH into the A&D Waiver, one additional Waiver enrollee could be newly covered in a fiscally neutral fashion.

i. Estimating the offsetting savings that can occur through the new Waiver enrollees remaining in the community setting longer, and delaying or altogether avoiding their becoming institutionalized Medicaid recipients.

The Waiver program serves as an important means of avoiding and delaying institutionalization. Many persons joining the Waiver program would otherwise have become an institutionalized Medicaid recipient at some future point in time. ***Table 17*** estimates the offsetting savings created due to Medicaid covering persons via the Waiver rather than via institutionalization. We believe that the Waiver will serve as a significant means of delaying and diverting institutionalization, but that it will take several years for the large-scale impacts to materialize. Initially, given that none of the new Waiver enrollees are institutionalized, we estimate that only 5 percent of FY2005 Waiver enrollees would otherwise be Medicaid NH residents *during FY2005* in the absence of the policy change. However, we project that this proportion will increase substantially, such that by FY2010 30 percent of the new Waiver enrollees would otherwise have been NH residents in FY2010, and that by FY2015 55 percent of

the new Waiver enrollees would otherwise have been institutionalized in that year. As the proportion of those diverted from the NH setting grows relative to the size of the NH Medicaid population, the average acuity of Medicaid NH residents should increase which may lessen some of the savings that diversion can create. The average acuity of those in the NH setting after diversion was not explicitly factored in, and could slightly increase the net costs of implementing SEA 493 beyond the costs projected herein.

The offsetting savings do not make the SEA 493 policy changes anything close to a "breakeven" fiscal proposition. However, transition and especially diversion do constitute a significant offset. The claims cost savings created by the "diversion" aspect of the Waiver are estimated to reach $30 million by FY2010 (offsetting 13 percent of the projected additional costs) and $84 million as of FY2015 (offsetting 24 percent of projected additional costs). Net annual Medicaid costs as of FY2017 are projected to be $165 million higher if SEA 493 is fully implemented, with the State share of these costs being $63 million. By FY2015, the annual net cost impact will increase to $258 million in total funds ($98 million in State funds).

Table 17. Net Cost Impacts of Program Design Changes Including Estimates of Savings Offsets

	FY2005	FY2006	FY2007	FY2010	FY2015
Discharges					
Baseline Nursing Home Population Estima	28,231	28,514	28,799	29,671	31,185
% Of NH Population To Transition to Waiv	0.3%	0.4%	0.5%	0.3%	0.1%
Number of NH Dischargees In Waiver	85	114	144	89	31
Monthly Savings Per Dischargee	***$919***	***$965***	***$1,013***	***$1,173***	***$1,497***
Total Annual Savings Due to Discharges	$934,242	$1,321,019	$1,751,175	$1,253,178	$560,332
Diversions					
Net Waiver Population Growth Due to Poli	1,537	5,872	6,531	7,049	8,490
% Who Would Be Medicaid Institutionalize	5%	10%	15%	30%	55%
Number of NH Diversions Enrolled In Waiv	77	587	980	2,115	4,670
Monthly Savings Per Diverted Individual	$919	$965	$1,013	$1,173	$1,497
Total Annual Savings Due to Diversions	$847,976	$6,801,229	$11,913,204	$29,771,562	$83,903,685
Total Offsetting Savings	$1,782,218	$8,122,248	$13,664,379	$31,024,740	$84,464,017
Total Cost Increase Before Offsets	$39,888,012	$152,848,854	$178,408,766	$222,925,238	$342,686,678
Net Cost Impact of Policy Change (State and Federal Funds Combined)					
	$38,105,793	**$144,726,606**	**$164,744,387**	**$191,900,498**	**$258,222,661**
Net Cost Impact of Policy Change (State Funds Only, Assuming 62% Federal Share)					
	$14,480,202	**$54,996,110**	**$62,602,867**	**$72,922,189**	**$98,124,611**

Lewin's estimates were tabulated annually through FY2015; years not presented above follow trends shown.

j. Estimating impacts of transitioning existing Choice Program enrollees enrolling in the expanded Waiver program.

As Choice Program enrollees are transitioned into the Waiver, two financial dynamics occur. First, payment for the coverage moves from being drawn solely from state funds to the shared federal/state funding under Medicaid. Second, under this transition the benefits package would expand from the Choice covered services (which are similar to the Waiver services) to full Medicaid coverage including primary and acute care. Data tabulated by State staff indicate that Choice enrollee costs during October 2004 averaged $334—far below the costs of providing full Medicaid coverage persons with these relatively significant levels of need. ***Table 18*** indicated that Waiver services accounted for 38 percent of the total Medicaid PMPM costs

incurred by Waiver enrollees during FY2003. Thus, the expense associated with moving to full Medicaid coverage is likely to completely offset the savings in state funds associated with receiving federal match on Waiver services. We therefore assume no net fiscal impacts from the phenomenon of Choice enrollees converting to the Waiver. It is also worth noting that the Choice program has no income limits regarding eligibility; thus not all Choice enrollees will be eligible to enroll in the Waiver even in the absence of a Waiver waiting list and with no spend-down requirement up to 300 percent of SSI.

k. Summary of Impacts

Our estimates modeled the costs of two simultaneous policy changes—removing the waiting list barrier to enrollment and eliminating spend-down requirements such that Waiver coverage entails no costs for persons with incomes up to 300 percent of SSI. These impacts are summarized in ***Table 18***.

Table 18. Summary, Impacts of Waiver Policy Changes

	FY2005	FY2006	FY2007	FY2010	FY2015
Total Cost Increase Before Offsets	$39,888,012	$152,848,854	$178,408,766	$222,925,238	$342,686,678
Offsetting Savings	$1,782,218	$8,122,248	$13,664,379	$31,024,740	$84,464,017
Net Cost Impact of Policy Change (State and Federal Funds Combined)					
	$38,105,793	**$144,726,606**	**$164,744,387**	**$191,900,498**	**$258,222,661**
Net Cost Impact of Policy Change (State Funds Only, Assuming 62% Federal Share)					
	$14,480,202	**$54,996,110**	**$62,602,867**	**$72,922,189**	**$98,124,611**
Enrolllment Without Policy Changes	3,918	4,022	4,127	4,455	5,366
Enrollment With Policy Changes	5,455	9,894	10,658	11,504	13,856
Percentage Increase	39%	146%	158%	158%	158%
Costs Without Policy Changes	$89,674,057	$96,658,966	$104,160,821	$130,150,980	$200,071,591
Costs With Policy Changes	$127,779,850	$241,385,572	$268,905,207	$322,051,478	$458,294,252
Percentage Increase	42%	150%	158%	147%	129%

Our key findings are summarized below:

- Removing the waiting list restriction and permitting enrollment without spend-down up for persons with incomes up to 300 percent of SSI would, over time, result in more than a doubling (158 percent increase) in Waiver enrollment. This coverage expansion is created by the large eligible population with income between 100-300 percent of SSI that currently cannot access the Waiver without spending down. The SEA 493 policy changes would be of significant benefit to these persons.
- The added cost of a new waiver enrollee is estimated to be approximately $23,000 in FY2005, versus $36,000 for institutionalized persons. Waiver enrollees who are new to the Medicaid program thus create a cost of $23,000 per person in that year; Waiver enrollees who would otherwise be Medicaid nursing home residents in that year create a *savings* of $13,000.
- The net additional costs associated with these design changes total more than $150 million per year (disregarding FY2005 and FY2006 which are assumed to be partial

impact years) from FY2007 forward, reaching $258 million in FY2015. The State share of these added Medicaid costs would be 38 percent (e.g., $98 million in FY2015).

- Claims costs in the Waiver would also more than double due to the policy changes. After factoring in savings offsets that gain momentum over time (due to nursing home diversion), claims costs are projected to be 129 percent higher in FY2015.
- While additional costs associated with the policy changes are dispersed across the various income cohorts from 0-300 percent of SSI, 52 percent of the enrollment and cost impacts are associated with persons between 100-200 percent of SSI, 39 percent between 200-300 percent of SSI, and 9 percent below 100 percent of SSI. The income subgroup that would benefit the most from the policy changes involves persons between 150-200 percent of SSI, who alone represent 31 percent of the additional enrollment and claims costs.
- If full Waiver coverage (with no spend-down) were extended only to persons with incomes up to 150 percent of SSI, net enrollment and cost impacts of SEA 493 would be only 30 percent of the amounts quantified in Tables 17 and 18.
- Working with the per enrollee cost estimates, a fiscally neutral option for the State would be to create a new waiver slot (for a currently uncovered person) for every two Medicaid recipients who are successfully transitioned from nursing homes onto the community-based Waiver program. A much broader array of policy options is discussed later in this report.

C. Administrative Steps and Costs

Expansion of an HCBS waiver program requires many complex considerations; in many ways growing an HCBS program is more complex than other LTC efforts because of its decentralized service system and emphasis on individualized outcomes. These traits make oversight, monitoring and performance measurement very challenging for all involved stakeholders.

Important considerations include outreach and education, intake and eligibility determination, calculation and collection of cost share (which SEA 493 eliminates under the A&D waiver), provider capacity development and quality assurance. As noted earlier, two years ago the U.S. General Accounting Office (GAO) released a report on quality assurance in HCBS waivers for persons with physical disabilities and of advanced age. The report was highly critical of state quality efforts for these waivers and, since then, CMS has placed greater pressure on states to improve quality practices.

OMPP and its partner agencies must ensure that appropriate administrative infrastructure is in place to guarantee the health, safety and welfare of waiver participants. This program could grow substantially under the direction of SEA 493, while at the same time, the State is managing significant changes in the current program including:

- Re-enrolling all providers in the Aged and Disabled waiver. This requires significant staff time to process applications and certify providers;
- Implementing a large-scale effort to increase the quality assurance program for the A&D waiver through a grant received from CMS;

- Modifying the contractual obligations of the AAAs;
- Procuring a new waiver consumer data tracking system to replace INsite; and
- Developing a new, consolidated Waiver Services Unit jointly administered by DDARS and OMPP.

This section provides an overview of key areas for consideration and estimated costs related to administrative operations of the A&D waiver program necessary to manage anticipated growth in the program for SFY2005 (1,339 new enrollees). Additional growth in the waiver, as discussed above, for years 2010 and 2015, would result in doubling or even tripling these costs depending on state operational structures, information technology, and managerial and executive decisions regarding acceptable costs.

In some areas, Lewin assumed growth related costs would be absorbed by existing infrastructure; in other areas Lewin notes potential increases in costs. As ***Tables 19 – 22*** outline below, the majority of new financial resources are needed to:

- Account for an increased need for case management staff at the local level;
- Adequately monitor the quality of the services being received by enrollees; and
- Adequately monitor contract compliance among the AAAs.

For some steps, it is assumed the task can be managed within existing resources. However, use of existing resources does require staff time, and staffing levels or responsibilities may need to be adjusted based on current workloads. It is also important to note, if the program continues to grow at rates anticipated in our analysis, use of existing resources will require re-evaluation in future years to ensure management and support levels are adequate for increased workload. Below, we provide specific estimates for staffing for the short term, 2005, in table form. For the "out years" (2010 -2015), where we estimate substantial enrollment growth, our administrative cost estimates focus instead on information technology tools that the state would likely need in order to monitor a program of the potential scale discussed above.

1. Eligibility and Case Management

Table 19. Short Term Eligibility and Case Management

Implementation Step	Responsible Entity	Time Frame	Resources
Modify eligibility process to allow up to 300 percent of SSI for elimination of post eligibility income ➢ EDS/staff to program ICES ➢ Train eligibility workers on changes including using the Waiver Client Eligibility Unit ➢ Issue provider bulletins on change	State	3 months	Existing
Process Financial Eligibility Applications	State	On-going	Existing
Process Functional Eligibility Applications	AAA	On-going	$32,000 (1 new FTE in OMPP LOC Unit)
Review a minimum of 15 percent of all Plans of Care	State	On-going	Existing
Provide case management services for enrollees	AAA	On-going	$744,000
Evaluate budget for staffing current and future system; acknowledge impact of automated systems.	OMPP, DDARS, DFC	6 months	Existing
Total			**$772,000**

In future years, assuming the waiver grows at the rates projected above, the state will need to consider the development of an automated financial and level of care eligibility system. Approximate costs for similar systems in other states are $4.5 million for the information technology and $450,000 to budget and management for contract oversight. If AAAs, as SEPs, used this system, additional costs for hardware would total $650,000 to $800,000 while an additional $720,000 would likely be needed per year for ongoing systems changes and maintenance. Indiana would also need to plan on $165,000 (3 FTE) for trainers. The total out year costs, assuming automation is pursued, is $6.49 - $6.6 million.

2. Provider Estimates

Table 20. Short Term Provider Capacity

Implementation Step	Responsible Entity	Time Frame	Resources
Simplify application process (i.e., DDARS and Medicaid processes)	DDARS, OMPP, AAAs	6 Months	TBD (depends on local entities resources and current staffing levels)
Complete plan for recruitment and to provide assistance to new providers Recruit and enroll new providers Certify providers for participation	DDARS, OMPP, and AAA New FTE and AAA	6-9 months	$27,000 (1 New FTE, discussed in Section VI)*
Provide on-going assistance to increased number of providers	DDARS, OMPP	On-going	$27,000
Monitor provider participation to determine if rate increases are required to have adequate number of providers for program	DDARS, OMPP	9 months	Existing
Develop policies for adult foster care	OMPP	3-6 months	$25,000
Plan and recommend changes to provider system including review of relational database information, AAA identified service gaps, etc.	DDARS, OMPP	12 months	May need more resources dependent on recommended changes
Total			**$79,000**

*The program is growing about 30 percent. Currently 2,400 providers for 2 certification specialists is 1,200 each. Assume adding one certification specialist for each 1,000 providers unless there are current challenges with workload.

In the future, to accommodate and monitor large numbers of HCBS providers, some states have purchased automated licensure and inspection systems to support state survey staff. Estimated costs include $2.5 million for the system, $250,000 for contract oversight, and $310,000 (6 FTE) per year to implement and maintain the system. Out year costs assuming this route is taken total $3.06 million.

3. Quality Estimates

Table 21. Short Term Quality Assurance

Implementation Step	Responsible Entity	Time Frame	Resources
Develop rules for Aged and Disabled Waiver surveys of provider and participants	State	3 months	Existing
Develop rules for funding transition services prior to transition to community.	State	3-6 months	Existing
Conduct quality surveys and site visits, including: ➢ Conduct surveys of 10 percent of all participating providers ➢ Conduct surveys of 10 percent of enrollees for each provider in a residential setting ➢ Conduct surveys of 10 percent of day habilitation sites ➢ Monitor nursing home to community transitions ➢ Conduct surveys of 10 percent of all enrollees ➢ Conduct quality monitor site visits with 20 percent of all enrollees ➢ Monitor incidence reporting ➢ Offer ongoing provider trainings on quality	State	On-going	$140,000
Quality: AAAs review 10 percent of participants by survey.	AAA	On-going	Existing
Total			**$140,000**

Estimated costs associated with quality are related primarily to staffing at the 2005 projected enrollment. In the out years, Indiana would have to expand its quality assurance strategy two-fold costing over $1 million, assuming the need for information technology.

4. Management and Administrative Support

Table 22. Short Term Management and Administrative Support

Implementation Step	Responsible Entity	Time Frame	Resources
Manage and support increased staffing levels and additional workload	DDARS, OMPP	On-going	Existing
Monitor AAA performance	DDARS, OMPP	On-going	$108,000
Complaints Investigation	OMPP	On-going	Existing
Hearings and Appeals	OMPP	On-going	Existing
Claims Payment and Billing	OMPP	On-going	Existing
Total			**$108,000**

Increased AAA oversight costs would likely be addressed in the short term, above, but increased numbers of participants and providers in the out years would likely necessitate increased numbers of state staff dedicated to complaints investigations and adjudicating consumer and provider hearings and appeals. Indiana already uses a sophisticated electronic billing and claims payment system; no new costs are anticipated barring any needed alterations or triggers in the EDS contract.

5. Summary of All Administrative Costs

Due to the number of waiver oversight and administration components currently under going improvements and organizational changes (i.e., development of the Waiver Services Unit, enhancement of the quality strategy, changes in AAA responsibilities and performance monitoring, and new service coordination/client tracking software), Lewin focused out year administrative estimates on automation and information technology that would likely be needed to support a program of the scale we estimate the A&D waiver program would approach. ***Table 23***, below, provides an overview.

Table 23. Short Term and Long Term Administrative Costs

Cost Area	2005 Estimate	Potential Out Year Estimate
Eligibility and Case Management	$772,000	$6.49 - $6.6 million
Provider Capacity	$79,000	$3.06 million
Quality Assurance	$140,000	$1 million
Management and Administrative Support	$108,000	TBD
Totals	$1.10 million	$10.6 - $10.7 million

VI. RECOMMENDATIONS

A. Overview

State governments offer an array of models for financing and delivering long term care for persons of all ages with disabilities. While individual program initiatives are important, ongoing and more comprehensive structural reform may be necessary to achieve a balanced and sustainable LTC delivery system. Implementation of SEA 493 would entail such sweeping change and, because of this, Indiana must consider an array of issues before undertaking major change to one of Medicaid's most critical support systems. For Indiana, changes to be considered include additional reductions in institutional capacity (without creating waiting lists for services) and shifting some funding to community-based settings. Such reform also may be accomplished through the continuation of strategic realignment of resources, financing, and infrastructure to achieve intended LTC results.

A state's system structure and management of its home and community-based delivery systems will determine whether HCBS becomes a cost-efficient alternative to institutions. While all states have made progress building HCBS delivery systems and some states have implemented model systems, most states' efforts have been hampered by a lack of investment in the administrative infrastructure for these programs and an approach to cost control that emphasizes placing limits on the number of people who could receive HCBS services, the amount they can receive, and keeping reimbursement as low as possible, while still attempting to maintain quality.

Weak infrastructure often results in long waiting lists for services, poor quality management, and a shortage of direct care workers. These inefficiencies can increase costs, because they: 1) minimize the likelihood that HCBS will serve someone who has been diverted from an institution versus someone who would have remained in the community; 2) create incentives for providers to charge up to the maximum and provide services when it is convenient to them rather than needed by the individual; and 3) lack mechanisms for managing the care of medically complex individuals, resulting in unnecessary hospitalizations and other acute care costs. While Indiana has made important strides in nursing home capacity reduction and HCBS expansions, there remain several other areas for consideration as the state addresses the significant systems change initiative required by SEA 493.

B. Recommendations to Enhance Indiana Capacity

Indiana LTC stakeholders, including DDARS, OMPP, AAAs, and advocacy groups, have addressed some of the elements above, including 1) nursing home cost containment efforts; 2) diversion and transition programs; and 3) efforts to streamline and consolidate waiver functions, such as waiting list management, at the state level. Specific findings and related recommendations for Indiana as it considers HCBS expansion as required in SEA 493 include:

1. Finding

In Indiana, approximately 70 percent of nursing home admissions come directly from hospitals. Hospital discharge planners tend to refer individuals in need of LTC to institutional settings more frequently than to community-based programs. Nationally, the vast majority of referrals from hospital discharge planners are for nursing home care, compared to one percent of referrals for A&D HCBS waivers.

Recommendation

- As part of the diversion and transition initiative, OMPP LTC staff and DDARS worked intensively with hospital discharge planners and pre-admission screening agencies. With SEA 493, Indiana agencies should expand significantly their relationships with hospital leadership to determine how to better educate discharge planners around HCBS options. OMPP and DDARS should assign a LTC point of contact for discharge planners to access and establish procedures for community-based agencies and for the discharge units to work together early in the discharge planning process; the Transitions Director could fill this role. Specific possible steps under this recommendation include:

  - Study the feasibility of hospitals, specifically discharge planners and rehabilitation staff, participating in Medicaid-financed Targeted Case Management (TCM) program or other Medicaid funded case management programs. Facilities licensed as TCM or as other Medicaid case management providers potentially could be reimbursed for case management services for Medicaid-eligible beneficiaries transitioning to HCBS service settings. Already the State of New Jersey is pursuing such plan under its Aging and Disability Resource Center (ADRC) grant project.

2. Finding

Few referrals for community-based programs originate from primary care providers (except those affiliated with home health agencies), according to providers and AAAs. Primary care providers, particularly physicians, often refer patients to institutional settings rather than community-based settings. Officials attribute this pattern to providers' lack of awareness of community-based alternatives ("primary care physicians are consistently unaware of the LTC options that exist in their communities") and to providers' response to limited community service capacity. Because primary care providers play such a critical role in linking patients to preventive and early intervention services, this lack of awareness presents a challenge in coordinating care.

Recommendation

- These findings indicate a need to better educate primary care providers about the existing array of services and to include them to a greater degree in the LTC planning process (e.g., AAAs and independent case managers). The development of targeted literature and educational forums describing LTC options, possibly by AAA region, would be beneficial in increasing physicians' awareness of program options at the local level. Building relationships with nurse practitioners, in particular, could be a cost-effective approach to coordinating medical and social care. One method of doing this is

to involve providers more in the care planning process. In addition, Medicaid-participating managed care organizations (MCOs), such as networks participating in Medicaid Select, could play a greater role in encouraging providers in their networks to refer individuals to other systems of care when appropriate.

3. Finding

Nationally, consumers and family members need to be better educated about their care choices in order to be able to make informed decisions. Based on The Lewin Group experiences, there is little systematic education of consumers around their LTC options and the financing thereof. Access to education and counseling is limited by an individual's locale. It was reported that outreach and education to caregivers, in particular, is not easily accessed.

Recommendation

- Consumers and family members should have access to information about LTC that is culturally appropriate and aligned with the timing of the individual's care needs and process (i.e., "information dosing" according to need at a given time), and addresses financing of their LTC choices. Partnerships with other sectors, such as the business community (to provide education to employees who are caregivers) and faith-based organizations, should be explored. "Options Counseling" could be made available through a centralized entity possibly through the AAA or resource networks that could offer information about service options as well as benefits counseling. All of these elements could be addressed through a linkage between HCBS expansion activities and Indiana's Aging and Disability Resource Center (ADRC) Grant.

4. Finding

LTC programs in Indiana have aspects of consumer direction that vary widely. Policies promoting self-determination have become a more recent priority within Indiana's system and manifests primarily through the inclusion of consumers in planning and policy development. Opportunities exist for greater consumer direction throughout the LTC system.

Recommendations

- Blend CPAS grant activity into SEA 493 implementation. Consider involving consumers and family members in discussions of consumer direction and the development of initiatives to enhance consumer direction for all LTC populations. Current contracts could be revisited to seek provisions for greater consumer direction. Flexible models of consumer direction could be explored that allow for variability in both consumers' preferences and abilities in participating in self-directed care and that promote planning around the family unit (not simply the individual).

- State agencies should accelerate plans to implement alternative forms of case management/support coordination such as a brokerage model (e.g., Wyoming DOORS) and the use of fiscal intermediaries. Ways to enable services to be more affordable for consumers and caregivers, thereby allowing greater access and choice in services, should be explored (e.g., sliding fee schedules). Consumers can have a larger advocacy role and

provide greater leadership than what currently exists. Such models also have reportedly yielded lower per-person costs in states such as Wyoming and New Jersey.

5. Finding

Indiana currently reimburses all waiver providers at the same rates for all individuals, regardless of service intensity needs and location in the state. Waiver rates are considered insufficient by providers who point out that without CHOICE payments they would be unable to sustain operations. AAAs craft CHOICE units of service and set CHOICE rates regionally but within the statewide list of CHOICE services.

Recommendations

- Study and draft a business model for a CHOICE/A&D waiver provider(s) to gain a better understanding of needed revenue to ensure stable, quality services.
- Explore the development of an assessment tool that would produce service need ratings in service tiers – tier one representing a low level of service need and tiers two through four representing higher levels of service needs, for example. Provider rates would be developed corresponding to the tiers. Tier one would have the lowest reimbursement rate while tier four would have the highest rate. Wisconsin uses a web-based assessment tool to assign tier levels and corresponding rates; case managers meet with consumers in their homes, conduct the assessment and report the tier assignment onsite. Such a system, while costly to establish, could yield both efficiencies in service costs for the state while also offering providers an incentive to serve people with more intense needs.

6. Finding

Indiana is currently centralizing many current AAA functions, such as waiting list management and is modifying the AAA contracts to include new statewide performance requirements. However, currently the State maintains only two staff in FSSA to oversee and support AAA activities.

Recommendations

- Increase staff responsible for AAA oversight and support (noted above); the State of Colorado maintains a unit of ten staff just for single point of entry operations. Such an increase would support AAA as they deal with waiver growth, offer opportunities to provide additional technical assistance to AAAs on the new contracting requirements, and could serve as support staff on diversion and transition efforts between AAAs and FSSA.
- FSSA could study the implications of competitive bidding for SEP contracts to encourage more efficient and competitive practices among the AAAs.

7. Finding

Indiana provides waiver case management through case managers housed in AAAs as well as a network of independent case managers who may or may not be associated with any specific AAA. They provide services as licensed case managers for both the A&D waiver as well as the Developmental Disabilities waiver. Indiana staff report that independent case managers are less likely to appropriately use INsite. Nationally, development of highly visible, trustworthy single point of entry systems is a high priority. Indiana has an Aging and Disability Resource Center grant from CMS to enhance its current AAA single point of entry network. Independent case managers, who operate autonomously and may or may not follow standard intake and referral practices, undermine the single point of entry concept. Furthermore, some independent case managers have developed relationships with providers, and questions regarding provider choice have been raised.

Recommendation

- Work with AAAs and any case manager trade association to advance nascent plans to increase oversight and performance monitoring of independent case managers as well as increase coordination between AAA and independent case managers.

8. Finding

Projected waiver growth will dramatically increase demand for HCBS waiver providers. Currently there are approximately 2,400 waiver providers, and the State has implemented a requirement that all CHOICE providers must also become waiver providers; this may significantly increase the number of waiver providers. Additionally, some provider recruitment efforts have been undertaken, especially in areas where the AAAs are or want to be providers. FSSA is developing a relational database system to better understand service use and needs throughout the state, especially rural and urban differences.

Recommendations

- Assign "Network Developer" responsibilities, as in Wisconsin, to an OMPP/DDARS waiver unit staff person to work with AAAs and providers on recruitment and retention.
- Consider economies of scale payments to providers and AAAs in very rural areas where it is especially difficult to recruit and retain both providers and staff.

9. Finding

Achieving cost effectiveness of SEA 493 *depends* on significant and aggressive diversion and transition efforts well beyond the state's current successful program, and closure of nursing home beds.

Recommendations

- OMPP and its partners should develop a broader strategy and specific timeframe for determining the number of persons residing in nursing homes who are possible

candidates for support in the community, thereby building on successes in the current transition program. (Such information will refine the estimates provided during this engagement.) Data collected from this effort also will inform the State of potential use of community-based services.

- Explore presumptive eligibility options for hospital discharges to ensure equal access to nursing home and HCBS such as Nebraska's Waiver While Waiting Program.
- Consider a work flow analysis of nursing home transition efforts; AAA and providers report difficulty in this area that impedes success.
- Institute pre-admission screening (PAS) requirements for *all* nursing home applicants both public and private pay. Before applicants are permitted to enter a nursing home, the states of Maine, Oregon, and Washington require a PAS for individuals applying for Medicaid nursing home services, as well as for home and community-based and other residential care. Maine requires PAS for both public pay (i.e., Medicaid) and private pay individuals.
- Continue partnering with nursing home associations to discuss strategies for permanently closing nursing home beds and converting nursing capital and resources into HCBS capital and resources. The state could provide technical assistance to nursing homes on converting to HCBS. This change could help increase the total number of waiver providers and help keep an important array of assets (i.e., nursing home administrators and professionals, direct support professionals, nursing home clinical staff, etc.) in the Indiana LTC system.

10. Finding

Waivers are not open-ended entitlements. States have the option to cap the number of people served and/or the amount of money they spend for waiver services. The current waiver preprint document offers states the option to manage their waivers to an established appropriation, using the dollars earmarked for the waiver as the cap on services. Indiana currently caps waiver enrollment at 6,000 and uses a slot allocation strategy among the AAAs and its Priority Diversion Program.

Recommendation

- At the renewal of the waiver, opt to manage to the waiver appropriation since CMS no longer requires states to serve only the number of individuals indicated in the waiver application.[67] Setting a cap on the number of persons served through the waiver is also an unnecessary cost control. Use a more individualized assessment and plan of care development strategy that tailors services and rates (i.e., tier system described above) more closely to individual consumer needs.

[67] See State Medicaid Directors' Letter Number 01-006, dated January 10, 2000.

11. Finding

The Indiana Client Eligibility System (ICES) has been the state's mainframe system since 1992. ICES is used by all local DFC offices to determine eligibility for TANF, Medicaid, Hoosier Healthwise, and Food Stamps. Separate data systems with FSSA, a separate cabinet level agency from DFC, operates data systems on Medicaid claims and billing, Medicaid participant LOC for the aged, blind and disabled aid codes, waiver specific data systems, and CHOICE data. Over the course of this engagement, it became apparent that these data systems are somewhat difficult to use and some do not communicate with others making program reporting cumbersome and time consuming.

Recommendation

- As part of broader health and human services planning, especially in light of changes in Medicaid and/or any state government re-organization that the newly elected Governor may propose, Indiana should consider strategies to enhance comprehensive LTC program reporting (see Concluding Recommendation below).

12. Finding

SEA 493 directs FSSA to develop strategies for increasing self-direction of services under the A&D waiver. Little is currently available regarding consumer direction under the current iteration of the waiver.

Recommendations

- Building on work conducted under the state's Consumer Directed Personal Assistance Services (C-PAS) grant, consider adding new services to the waiver that would foster consumer direction as well as support individuals receiving supports in their families' homes. Possible services include:

  - *Consumer Education*—Other states crafted this benefit to provide consumers with basic information on the waiver and their services. They also attempt to provide consumers with self-advocacy skills that may be used in POC development meetings or other service planning events. Typical providers are Centers for Independent Living, Protection and Advocacy Agencies, Developmental Disabilities Councils, and AAAs. Other services definitions would need to be amended to allow consumers to exercise the skills acquired under this benefit.
  - *Family Support Services* – This is a service or package of services typically offered in developmental disabilities programs either as a state general fund program or a waiver service. These services are intended to assist a family unit to remain together and to support the family member with a disability at home. Services include respite, family counseling and therapy, home modifications, and, where needed, behavior intervention training. Such a service package would increase the likelihood that consumers who wish to remain at home with families could do so.

- FSSA also could consider converting the waiver to the Section 1915(c) Independence Plus template at the A&D waiver renewal.

13. Finding

Indiana has not explored strategies that would allow the state to better coordinate and manage acute and long term care services and related funding streams.

Recommendations

States have explored a variety of strategies to better coordinate acute or medical services for persons with disabilities and individuals of advanced age as well as better manage service dollars. Indiana should explore:

- Integrated Acute and Long Term Managed Care Models—The Arizona Long Term Care System (ALTCS) uses a managed care model to provide long term supports for persons of advanced age and people with physical and/or developmental disabilities. In Arizona's largest county, Maricopa County, three managed long term care plans compete with one another with one another to provide a complete array of all Medicaid-covered services for their members, including acute care services, behavioral health services, long term supports, and the provision of prescription medications. CMS has pointed to ALTCS has an effective model for using a capitation methodology to rebalance long term care systems towards HCBS. Similar arranges are operating in Texas, STAR-Plus, and in Michigan.[68]
- Global Budgeting—Global budgeting allows states to cap total long term care spending but, and more importantly, to have much greater administrative freedom to manage costs within the spending limit and move dollars from one service area, such as nursing homes, to other service areas (i.e., HCBS). A recent paper asserts that the result of global budgeting is "that programs form an interrelated whole that is best managed when state officials have the freedom and flexibility to control caseloads and costs within a single spending authority."[69] States, such as Oregon, Texas, Vermont, and Washington, all are identified as having this important administrative tool that allows "money to follow the person." Indiana has some flexibility in this area but the state and key stakeholders should explore avenues to enhance FSSA's capacity to shift long term care dollars as needed.

[68] See State Medicaid Directors' Letter Number 03-008, dated September 17, 2003.

[69] Reinhard, S., RN, PhD., & Hendrickson, L., PhD. Global Budgeting: Promoting Flexible Funding to Support Long-Term Care Choices, Rutgers Center for State Health Policy, October 2004.

VII. CONCLUDING RECOMMENDATION

Considering the growth Lewin estimates, current administrative infrastructure likely will not meet consumer demand for HCBS an array of new local and state staff that will be needed to accommodate HCBS expansion. Additionally, state and local agencies have expressed concerns regarding whether they have the appropriate tools and systems in place to grow the waiver program in a safe and effective manner while producing lower or no new long term care costs. Budget constraints and Medicaid budget forecasts also are barriers to building community-based services and improving coordination of existing services.

Indiana has taken steps to improve HCBS operations via the development of the Waiver Services Unit and is examining the role of AAAs, OMPP and DDARS in day to day HCBS operations. Additionally, an SEA 493 implementation team was established after enactment of the measure to oversee implementation. However, the development of an inclusive, *action oriented* strategic LTC plan would build on the important steps FSSA and the broader stakeholder community already have taken while addressing key service challenges and responding to constituency requests in a manner that will ensure program participant safety and that will offer Indiana a sustainable LTC system.

The rapid pace of change in both the Medicaid and LTC environment (the two are inherently interrelated) and the complexity of the issues to be addressed dictates that any effort to create and sustain change within a publicly administered LTC system must be guided by a carefully developed strategic plan. Already, the state has developed several strategic planning processes related to LTC including ***Olmstead*** and the developmental disabilities facility closure plan. An SEA 493 Strategic Plan should be developed by people with detailed knowledge of Indiana's Medicaid program and long term care systems – primarily state officials *with decision making authority who also are answerable to a body of key stakeholders,* such as consumers and family advocacy organizations, providers, including nursing home and HCBS providers, and legislators responsible for health and human services issues and budgeting. The strategic process would have three qualities. First, the plan must *integrate* the operational structure of all state agencies responsible for portions of the LTC system -- including eligibility and licensure, the issues faced by the LTC system and its key non-governmental partners, including, service providers, and statewide advocates, and its public constituency. Of key importance to Indiana in this area are information systems that do not communicate well and past divisions of responsibilities among state agencies.

Second, the initiative must be *skills-based* – that is, including elements to improve the individual and collective capacity of DDARS and OMPP staff as well as other LTC system stakeholders to implement the strategic plan and to respond to challenges. This could include enhanced training opportunities for consumers and providers on consumer direction, small business training opportunities for providers interested in expanding into under-served areas of the state, such as southern Indiana, as well as for consumers and families who might be interested in developing micro-boards or Family-to-Family Support Networks. Finally, the process must be *iterative*, one in which problems are identified, acted on and learned from. This learning is then carried on to the next issue or challenge. This approach could also focus on addressing

aspects of the Indiana LTC culture that includes leadership, organization, staffing, values, attitudes, and problem solving strategies.

As part of the strategic planning process, Indiana would conduct an analysis of its current LTC operational environment as well as develop a vision for the target LTC service environment. The former would include conducting a comprehensive community needs assessment to determine the type, number and distribution of community services in the state. Based on our review of the literature and operational experience, Indiana should pursue the following common themes in a strategic plan aimed at SEA 493 implementation:

1. Access

- ***Targeting of access to HCBS through eligibility criteria, both financial and functional.*** Some states broaden the financial and functional eligibility criteria in an effort to intervene early so as to prevent institutionalization (WA and OR) while others take a more restrictive approach to eligibility to keep costs down (MD).

- ***Expedited eligibility processes and diversionary efforts.*** Including identification of individuals prior to permanent institutionalization through easily accessible and consistent screening methods in several forums – through a central source in the community (single entry points), upon discharge from a hospital (WI), and within the first month of a nursing facility stay (WA). Also develop alternatives to institutional care to allow for a broader range of individuals to be served in the community in a cost-efficient manner (i.e., since residential alternatives cost less than institutional care).

- ***Elimination or effective management of waiting lists.*** Expanded access to HCBS permits strategic targeting of the level-of-care criteria that allows individuals to obtain community services prior to the support situation deteriorating (WA, PA). Other states use mechanisms to triage waiting lists so that those most at risk for institutionalization receive higher priority. This could minimize the deleterious effect of waiting lists on actual diversions from institutions.

- ***Ensuring sufficient community-based capacity.*** This step can include provider certification, use of alternative providers such as family members, and encouragement of alternative residential settings (incentives to convert institutional beds), so that appropriate, safe, and cost-effective alternatives are available.

2. Cost

- ***Efficient person-based financing for HCBS based on need and available resources***. This aspect provides funds for appropriate services in the least restrictive setting, utilizes non-state funds (Medicare, Older Americans Act, federal Medicaid match), uses independent providers to keep costs down (less overhead than agency-based services), integrates and supports unpaid care to maintain individuals in the community longer, and establishes individual budgets based on standardized assessments of need. Interesting examples in this area include efforts to establish reimbursement methodologies that are driven more directly by assessments (AZ, DE, DC, MN). Many

states also are pursuing consumer-directed services so that individuals can make the most appropriate and cost-effective choices for their supports.

- ***Tactics to transfer funding from institutions to HCBS.*** These tactics involve securing language in appropriations bills to transfer state general fund dollars from the nursing facility (NF) category to the HCBS category for each identified NF diversion/conversion. This strategy will create momentum to expand HCBS (TX), capitate the institutional care costs for all people meeting the NF level of care, and retain a managed care entity with an incentive to place individuals in community settings (DE). In addition, seek a broad 1115 waiver or 1915(b)/(c) combination to remove the entitlement to NF services and replace it with an entitlement to "long term care services" which could be met in a setting-neutral way (WI).

- ***Strategies to provide incentives for institutional providers to provide quality care to those in need of intensive services, but to reduce unnecessary beds and payments for building new beds.*** Over time phase out: 1) the institutional reimbursement formula; and 2) any payment related to depreciation costs for capital (new construction/renovation). At the same time, permit such reimbursement in assisted living payment rates, thereby inducing capital to move into assisted living (ND). Establish a fund (using tobacco settlement or other resources) that would pay institution operators to permanently de-certify beds, replenishing the fund over time by a formula tied to "avoided" costs related to those decertified beds (NE, MN).

3. Quality

- ***Performance-based incentives for providers and consumer input regarding provider and program performance***. Focus on outcomes in areas of importance to consumers and the program (choice and self-determination, community integration, health and safety, and costs), provide incentives to produce desired outcomes, incidence reporting, and provider qualifications.

- ***Flexibility and creativity in meeting individuals' needs.*** This step requires skilled support coordination, sufficient training and empowerment of consumers, available supports, knowledge of all sources of care received and the authority to make creative decisions for both the participant and the individuals authorizing/approving the approach. In addition, some states encourage the use of consumer-controlled independent providers for personal care (consumer-direction) and relaxed nurse delegation requirements, so that others might provide many of the routine tasks (e.g., injections) more efficiently.

4. Infrastructure

- ***Management information systems to monitor progress and adjust as needed.*** In order to understand whether management techniques are effective, it is critical that management information systems (MIS) provide real-time or near-real-time information to determine whether desired performance goals have been met.

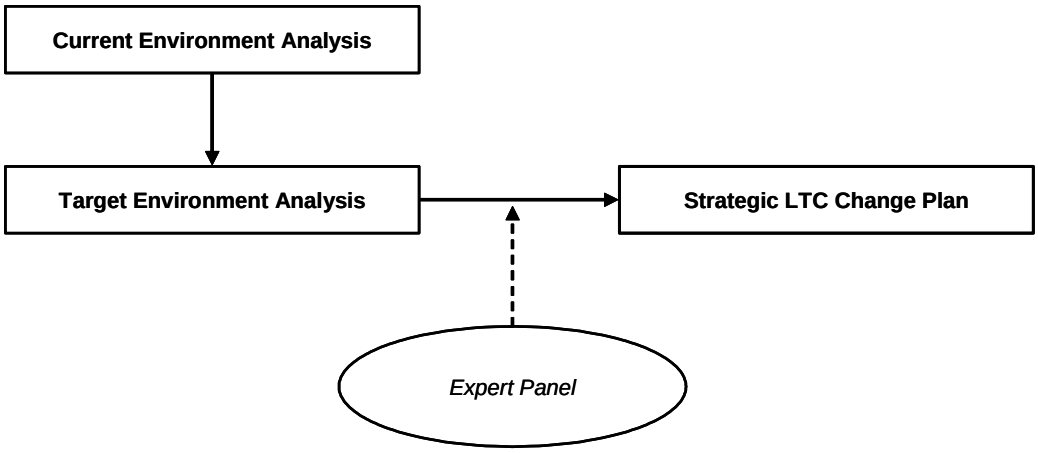
- ***Locus of control.*** This includes organization of the system at the state level, whether programs are administered at the regional or local level, the use of single entry points, and the role of local funds in financing services.

- ***Linkages to non-Medicaid supports.*** This topic focuses on the role of Medicaid in the larger long term care system and the extent to which other long term care programs are coordinated and integrated rather than operated as silos, as well as the degree to which other supports are brought to bear (employment, income maintenance, housing, transportation).

The Governor of Louisiana recently convened a blue ribbon committee of national experts to support the State in assessing the state's *entire* LTC system including Medicaid-financed services, State General Fund programs, and services funded through other federal programs or grants.

Following an assessment of the current LTC environment, the SEA 493 Strategic Planning Team would develop a target environment analysis laying out the components that would have to be in place to effectively and efficiently implement the measure. The strategic plan also would include a timeline providing a pace that is financially acceptable to taxpayers and budget officials – both state agency and legislators – and that allows time to develop the appropriate community capacity. The strategic plan would serve as the detailed work plan for moving from the current environment to the target environment. ***Figure 7,*** below, depicts a possible strategic process.

Figure 7. Possible Framework for LTC Change Initiative



Indiana LTC stakeholders have made significant strides in the evolution of the state's LTC system including CHOICE, the development of a single point of entry system, and significant expansions in HCBS waiver programs. SEA 493 presents Indiana with a daunting and exciting systems change challenge that would build on previous work. However, SEA 493 will also require significant planning and thought to ensure a safe and sustainable LTC system. An inclusive strategic planning process that would allow careful analysis of challenges and

opportunities, it would also create a forum for the development of the State's LTC vision and goals and would provide a framework for addressing this critical area of the health care system.

Appendix A
Questionnaires

Indiana's Aged and Disabled Waiver Questionnaire

The Lewin Group has been engaged by the Indiana Office of Medicaid Policy and Planning (OMPP) to conduct a quantitative assessment of potential costs and savings associated with raising the allowable income eligibility level for participation in the Medicaid Aged and Disabled Home and Community-Based Services (HCBS) waiver and the impact of the corresponding increase in waiver participants on administrative infrastructure, provider recruitment, service provision and community capacity.

Lewin has developed the attached questionnaire to gather information on the administration of Indiana's Aged and Disabled waiver. There may be questions in the questionnaire which are not applicable to your organization. If so, please mark "NA". If you wish to express observations on a question that does not directly pertain to your organization or role in the waiver, please use Part IV. Other Comments.

Thank you for your willingness to respond to the questionnaire. Please complete this form and return it to Melissa.Rowan@Lewin.com by ***June 18, 2004***. If you have questions or need assistance, please contact Melissa Rowan at Melissa.Rowan@Lewin.com or 703-269-5778. The information received through this questionnaire is confidential. Any information shared with the state will not identify the party providing the information.

We appreciate your assistance with this project.

The Lewin Group

PART I. ORGANIZATION IDENTIFICATION

Please provide the following information on your organization:

Organization Name:
Address:
Contact Person Name:
Contact Person Phone:
Contact Person Email:

PART II. ADMINISTRATIVE INFRASTRUCTURE

Eligibility Determination and Intake

1. What is your organization's role in the eligibility determination process for the Elderly and Disabled Waiver? Please specifically address:
   a. level of care

   b. financial

   c. disability determination

   d. Average processing time for each of the above

2. How many full time equivalents (FTE) are currently determining eligibility?
   a. What is the average caseload per FTE?

   b. What is the maximum acceptable caseload per FTE?

   c. What is the average hourly wage per FTE?

3. Describe your organization's role in reassessing a consumer's eligibility status.
   a. When does this occur and what is the length of time to make a decision?

   b. What entities are involved?

   c. How do you ensure that eligibility re-determination is timely?

   d. What measures are in place to prevent ineligible consumers from continuing to receive services?

4. Describe the process for identification and selection of Aged and Disabled Waiver services providers. Please address the following:
   a. Initial service providers at time of waiver intake

   b. Identification and selection of service providers if changes are needed

   c. Challenges associated with identifying providers at both points (i.e., rural issues, provider waiting lists, direct support worker shortages, etc.)

Service Planning (Plan of Care)

1. What is your organization's role in the service plan development and plan review process for the Aged and Disabled Waiver?

2. How often are service plans reassessed?

3. Are professional certifications required of staff conducting service planning functions? (Please specify)

4. How many full time equivalents (FTE) are typically engaged in service planning?

5. What is the average caseload of individuals responsible for developing and maintaining service plans per FTE?

6. What is the average hourly wage of staff responsible for developing and maintaining service plans per FTE?

Case Management

1. What is your organization's role in the case management process for the Aged and Disabled Waiver?

2. How is the level of case management determined (i.e., number of hours of direct contact; possibilities include community transition, periods of behavioral instability, etc.)?

3. Are professional certifications required of staff performing case management functions? (Please specify)

4. How many full time equivalents (FTE) are currently providing case management services?

5. What is the average caseload per FTE?

6. What is the average hourly wage per FTE?

Quality Assurance

1. Please describe the quality assurance/improvement functions for the Aged and Disabled Waiver performed by your organization. Please provide information on the number of

contacts or percent of cases impacted. Please describe FTEs needed to conduct the functions and average hourly wage per FTE. Please address, at a minimum, the following:

a. satisfaction surveys

b. financial fraud prevention

c. complaint resolution

d. incident reporting, investigation and resolution

Information and Referral

a) What is your organization's role in providing information and referral to the community for the Aged and Disabled Waiver?

b) On average, how many inquiries do you receive on the Aged and Disabled Waiver per month?

c) How many full time equivalents (FTE) are currently providing information and referral services?

d) What is the average hourly wage per FTE?

Diversion and Transition Programs

Indiana has policies and programming intended to reduce utilization of nursing home services. The state currently has support programs intended to "divert" individuals from nursing home settings to HCBS services by providing needed information and services before they enter a nursing home. Indiana also is "transitioning" some nursing home residents who have expressed an interest in moving back to their homes and communities. Please describe your experiences with these programs addressing:

a. Eligibility Determination

b. Identification and Section of Service Providers

c. For Transitioning Individuals use of the Community Transition Benefit

d. Outreach and Education Strategies on Diversions and Transition Programs

PART III. SERVICE PROVIDER RECRUITMENT AND RETENTION

1. Have you encountered providers who require a minimum number of service hours? If so, how have you addressed this issue?

2. What strategies do you use to recruit providers to serve in rural or other underserved areas?

3. What resources (financial, staffing, time) are required to implement provider recruitment activities? What are necessary ongoing resources?

4. What are the greatest challenges associated with recruiting HCBS waiver providers?

5. Direct Support Worker Capacity:
   a. If more waiver recipients wanted services from your organization, would you have the capacity at current staffing levels? ☐ Yes ☐ No
      If no, is there additional professional staff available in your community?

   b. Are there any professional shortages which would limit your ability to expand service provision? ☐ Yes ☐ No
      If yes, please describe.

6. Provide a description of a recently opened program or service site; please address the following points:
   a. Identification and securing of a service site (time and costs)

   b. Staffing acquisition and training (time and costs) for direct service, managerial, and administrative

   c. Licensure and Certification

   d. Establishment of revenue stream (i.e., provider enrollment in Medicaid claims payment system)

   e. Overall cost and time frame for development of new programs or new program sites.

7. Does your organization participate in formal trainings about the waiver program? Is it required?
   a. What type of trainings?

   b. Who conducts these trainings?

   c. How often are these offered?

   d. Do waiver providers convene or share information with one another?

8. How do waiver payment rates compare to similar service payment rates in other Medicaid programs in your state?

9. How do waiver payment rates compare to CHOICE payment rates?

10. What opportunities or challenges would your organization encounter if you served more Aged and Disabled waiver participants? Assume that the reimbursement, regulatory, and administrative environment is the same as the current system.

PART IV. SERVICE PROVISION

1. Please identify which waiver services your organization provides.
   - Case Management ☐
   - Homemaker ☐
   - Respite ☐
   - Adult Day Services ☐
   - Environmental Modifications ☐
   - Transportation ☐
   - Specialized Medical Equip. and Supplies ☐
   - Personal Emergency Response Systems ☐
   - Attendant Care Services ☐
   - Adult Residential Care ☐
   - Adult Foster Care ☐
   - Assisted Living ☐
   - Community Transition Services ☐
   - Congregate Care ☐
   - Home Delivered Meals ☐
   - Nutritional Supplements ☐
   - Pest Control ☐

2. Please provide the number of waiver consumers served in FY 2003 by service.
   - Case Management
   - Homemaker
   - Respite
   - Adult Day Services
   - Environmental Modifications
   - Transportation
   - Specialized Medical Equip. and Supplies
   - Personal Emergency Response Systems
   - Attendant Care Services
   - Adult Residential Care
   - Adult Foster Care
   - Assisted Living
   - Community Transition Services
   - Congregate Care
   - Home Delivered Meals
   - Nutritional Supplements
   - Pest Control

3. a. For each service you provide, what is the maximum acceptable staff to consumer ratio, where applicable?
   - Case Management
   - Homemaker
   - Respite
   - Adult Day Services
   - Environmental Modifications
   - Transportation

Specialized Medical Equip. and Supplies
Personal Emergency Response Systems
Attendant Care Services
Adult Residential Care
Adult Foster Care
Assisted Living
Community Transition Services
Congregate Care
Home Delivered Meals
Nutritional Supplements
Pest Control

b. Are you currently fully staffed to provide services at caseloads you consider acceptable?
☐ Yes ☐ No

c. For each type of service you provide, what is the average cost per service?
Case Management
Homemaker
Respite
Adult Day Services
Environmental Modifications
Transportation
Specialized Medical Equip. and Supplies
Personal Emergency Response Systems
Attendant Care Services
Adult Residential Care
Adult Foster Care
Assisted Living
Community Transition Services
Congregate Care
Home Delivered Meals
Nutritional Supplements
Pest Control

4. Diversion and Transition Programs
Indiana has policies and programming intended to reduce utilization of nursing home services. The state current is support programs intended to "divert" individuals from nursing home settings to HCBS services by providing needed information and services before they enter a nursing home. Indiana also is "transitioning" some nursing home residents who have expressed an interest in moving back to their homes and communities. Please describe your experiences with these programs addressing:

e. Eligibility Determination

f. Identification and Section of Service Providers

g. For Transitioning Individuals use of the Community Transition Benefit

h. Outreach and Education Strategies on Diversions and Transition Programs

PART V. OTHER COMMENTS

Use this section to provide any information on HCBS waiver operations that would be impacted by an increase in the number of waiver participants.

Please complete this form and return it to Melissa.Rowan@Lewin.com If you have questions or need assistance, please contact Melissa Rowan at Melissa.Rowan@Lewin.com or 703-269-5778.

We appreciate your assistance with this project. Thank you.

Indiana's Aged and Disabled Waiver Questionnaire for Service Providers

The Lewin Group has been engaged by the Indiana Office of Medicaid Policy and Planning (OMPP) to conduct a quantitative assessment of potential costs and savings associated with raising the allowable income eligibility level for participation in the Medicaid Aged and Disabled Home and Community-Based Services (HCBS) waiver and the impact of the corresponding increase in waiver participants on service provision and community capacity.

Lewin has developed the attached questionnaire to gather information on the administration of Indiana's Aged and Disabled waiver. There may be questions in the questionnaire which are not applicable to your organization. If so, please mark "NA". If you wish to express observations on a question that does not directly pertain to your organization or role in the waiver, please use Part IV. Other Comments.

Thank you for your willingness to respond to the questionnaire. Please complete this form and return it to Melissa.Rowan@Lewin.com by ***June 18, 2004***. If you have questions or need assistance, please contact Melissa Rowan at Melissa.Rowan@Lewin.com or 703-269-5778. The information received through this questionnaire is confidential. Any information shared with the state will not identify the party providing the information.

We appreciate your assistance with this project.

The Lewin Group

PART I. ORGANIZATION IDENTIFICATION

Please provide the following information on your organization:

Organization Name:
Address:
Contact Person Name:
Contact Person Phone:
Contact Person Email:

PART II. SERVICE PROVISION

1. Please identify which waiver services your organization provides.
   - Case Management ☐
   - Homemaker ☐
   - Respite ☐
   - Adult Day Services ☐
   - Environmental Modifications ☐
   - Transportation ☐
   - Specialized Medical Equip. and Supplies ☐
   - Personal Emergency Response Systems ☐
   - Attendant Care Services ☐
   - Adult Residential Care ☐
   - Adult Foster Care ☐
   - Assisted Living ☐
   - Community Transition Services ☐
   - Congregate Care ☐
   - Home Delivered Meals ☐
   - Nutritional Supplements ☐
   - Pest Control ☐

2. Please provide the number of waiver consumers served in FY 2003 by service.
   - Case Management
   - Homemaker
   - Respite
   - Adult Day Services
   - Environmental Modifications
   - Transportation
   - Specialized Medical Equip. and Supplies
   - Personal Emergency Response Systems
   - Attendant Care Services
   - Adult Residential Care
   - Adult Foster Care
   - Assisted Living
   - Community Transition Services
   - Congregate Care
   - Home Delivered Meals
   - Nutritional Supplements
   - Pest Control

3. a. For each service you provide, what is the maximum acceptable staff to consumer ratio, where applicable?

Case Management
Homemaker
Respite
Adult Day Services
Environmental Modifications
Transportation
Specialized Medical Equip. and Supplies
Personal Emergency Response Systems
Attendant Care Services
Adult Residential Care
Adult Foster Care
Assisted Living
Community Transition Services
Congregate Care
Home Delivered Meals
Nutritional Supplements
Pest Control

b. Are you currently fully staffed to provide services at caseloads you consider acceptable?

☐ Yes ☐ No

c. For each type of service you provide, what is the average cost per service?

Case Management
Homemaker
Respite
Adult Day Services
Environmental Modifications
Transportation
Specialized Medical Equip. and Supplies
Personal Emergency Response Systems
Attendant Care Services
Adult Residential Care
Adult Foster Care
Assisted Living
Community Transition Services
Congregate Care
Home Delivered Meals
Nutritional Supplements
Pest Control

5. Diversion and Transition Programs

Indiana has policies and programming intended to reduce utilization of nursing home services. The state currently has support programs intended to "divert" individuals from nursing home settings to HCBS services by providing needed information and services before they enter a nursing home. Indiana also is "transitioning" some nursing home residents who have expressed an interest in moving back to their homes and communities. Please describe your experiences with these programs addressing:

a. Eligibility Determination

b. Identification and Section of Service Providers

c. For Transitioning Individuals use of the Community Transition Benefit

d. Outreach and Education Strategies on Diversions and Transition Programs

PART III. SERVICE PROVIDER RECRUITMENT AND RETENTION

1. Direct Support Worker Capacity:

   a. If more waiver recipients wanted services from your organization, would you have the capacity at current staffing levels? ☐ Yes ☐ No

      If no, is there additional professional staff available in your community?

   b. Are there any professional shortages which would limit your ability to expand service provision? ☐ Yes ☐ No

      If yes, please describe.

2. Provide a description of a recently opened program or service site; please address the following points:

   a. Identification and securing of a service site (time and costs)

   b. Staffing acquisition and training (time and costs) for direct service, managerial, and administrative

   c. Licensure and Certification

   d. Establishment of revenue stream (i.e., provider enrollment in Medicaid claims payment system)

   e. Overall cost and time frame for development of new programs or new program sites.

3. Does your organization participate in formal trainings about the waiver program? Is it required?
   a. What type of trainings?
   b. Who conducts these trainings?
   c. How often are these offered?
   d. Do waiver providers convene or share information with one another?

4. How do waiver payment rates compare to similar service payment rates in other Medicaid programs in your state?

5. How do waiver payment rates compare to CHOICE payment rates?

6. What opportunities or challenges would your organization encounter if you served more Aged and Disabled waiver participants? Assume that the reimbursement, regulatory, and administrative environment is the same as the current system.

PART IV. OTHER COMMENTS

Use this section to provide any information on HCBS waiver operations that would be impacted by an increase in the number of waiver participants.

Please complete this form and return it to Melissa.Rowan@Lewin.com If you have questions or need assistance, please contact Melissa Rowan at Melissa.Rowan@Lewin.com or 703-269-5778.

We appreciate your assistance with this project. Thank you.

Indiana's Aged and Disabled Waiver Questionnaire for AAAs

The Lewin Group has been engaged by the Indiana Office of Medicaid Policy and Planning (OMPP) to conduct a quantitative assessment of potential costs and savings associated with raising the allowable income eligibility level for participation in the Medicaid Aged and Disabled Home and Community-Based Services (HCBS) waiver and the impact of the corresponding increase in waiver participants on administrative infrastructure and provider recruitment.

Lewin has developed the attached questionnaire to gather information on the administration of Indiana's Aged and Disabled waiver. There may be questions in the questionnaire which are not applicable to your organization. If so, please mark "NA". If you wish to express observations on a question that does not directly pertain to your organization or role in the waiver, please use Part IV. Other Comments.

Thank you for your willingness to respond to the questionnaire. Please complete this form and return it to Melissa.Rowan@Lewin.com by ***September 3, 2004***. If you have questions or need assistance, please contact Melissa Rowan at Melissa.Rowan@Lewin.com or 703-269-5778. The information received through this questionnaire is confidential. Any information shared with the state will not identify the party providing the information.

We appreciate your assistance with this project.

The Lewin Group

PART I. ORGANIZATION IDENTIFICATION

Please provide the following information on your organization:

Organization Name:
Address:
Contact Person Name:
Contact Person Phone:
Contact Person Email:

PART II. ADMINISTRATIVE INFRASTRUCTURE

Eligibility Determination and Intake

1. What is your organization's role in the eligibility determination process for the Aged and Disabled Waiver? Please specifically address:
   a. level of care
   b. financial
   c. disability determination
   d. Average processing time for each of the above
2. How many full time equivalents (FTE) are currently determining eligibility?
   a. What is the average caseload per FTE?
   b. What is the maximum acceptable caseload per FTE?
   c. What is the average hourly wage per FTE?
3. Describe your organization's role in reassessing a consumer's eligibility status.
   a. When does this occur and what is the length of time to make a decision?
   b. What entities are involved?
   c. How do you ensure that eligibility re-determination is timely?
   d. What measures are in place to prevent ineligible consumers from continuing to receive services?

4. Describe the process for identification and selection of Aged and Disabled Waiver services providers. Please address the following:

   a. Initial service providers at time of waiver intake

   b. Identification and selection of service providers if changes are needed

   c. Challenges associated with identifying providers at both points (i.e., rural issues, provider waiting lists, direct support worker shortages, etc.)

Service Planning (Plan of Care)

1. What is your organization's role in the service plan development and plan review process for the Aged and Disabled Waiver?

2. How often are service plans reassessed?

3. Are professional certifications required of staff conducting service planning functions? (Please specify)

4. How many full time equivalents (FTE) are typically engaged in service planning?

5. What is the average caseload of individuals responsible for developing and maintaining service plans per FTE?

6. What is the average hourly wage of staff responsible for developing and maintaining service plans per FTE?

Case Management

1. What is your organization's role in the case management process for the Aged and Disabled Waiver?

2. How is the level of case management determined (i.e., number of hours of direct contact; possibilities include community transition, periods of behavioral instability, etc.)?

3. Are professional certifications required of staff performing case management functions? (Please specify)

4. How many full time equivalents (FTE) are currently providing case management services?

5. What is the average caseload per FTE?

6. What is the average hourly wage per FTE?

Quality Assurance

1. Please describe the quality assurance/improvement functions for the Aged and Disabled Waiver performed by your organization. Please provide information on the number of contacts or percent of cases impacted. Please describe FTEs needed to conduct the functions and average hourly wage per FTE. Please address, at a minimum, the following:
   a. satisfaction surveys
   b. financial fraud prevention
   c. complaint resolution
   d. incident reporting, investigation and resolution

Information and Referral

a) What is your organization's role in providing information and referral to the community for the Aged and Disabled Waiver?

b) On average, how many inquiries do you receive on the Aged and Disabled Waiver per month?

c) How many full time equivalents (FTE) are currently providing information and referral services?

d) What is the average hourly wage per FTE?

Diversion and Transition Programs

Indiana has policies and programming intended to reduce utilization of nursing home services. The state currently has support programs intended to "divert" individuals from nursing home settings to HCBS services by providing needed information and services before they enter a nursing home. Indiana also is "transitioning" some nursing home residents who have expressed an interest in moving back to their homes and communities. Please describe your experiences with these programs addressing:

a. Eligibility Determination

b. Identification and Section of Service Providers

c. For Transitioning Individuals use of the Community Transition Benefit

d. Outreach and Education Strategies on Diversions and Transition Programs

PART III. SERVICE PROVIDER RECRUITMENT AND RETENTION

1. Have you encountered providers who require a minimum number of service hours? If so, how have you addressed this issue?

2. What strategies do you use to recruit providers to serve in rural or other underserved areas?

3. What resources (financial, staffing, time) are required to implement provider recruitment activities? What are necessary ongoing resources?

4. What are the greatest challenges associated with recruiting HCBS waiver providers?

5. Does your organization participate in formal trainings about the waiver program? Is it required?
   a. What type of trainings?

   b. Who conducts these trainings?

   c. How often are these offered?

   d. Do waiver providers convene or share information with one another?

6. How do waiver payment rates compare to similar service payment rates in other Medicaid programs in your state?

7. How do waiver payment rates compare to CHOICE payment rates?

8. What opportunities or challenges would your organization encounter if you served more Aged and Disabled waiver participants? Assume that the reimbursement, regulatory, and administrative environment is the same as the current system.

PART IV. OTHER COMMENTS

Use this section to provide any information on HCBS waiver operations that would be impacted by an increase in the number of waiver participants.

Please complete this form and return it to Melissa.Rowan@Lewin.com If you have questions or need assistance, please contact Melissa Rowan at Melissa.Rowan@Lewin.com or 703-269-5778.

We appreciate your assistance with this project. Thank you.

Appendix B
CMS “Money Follows the Person” Letter to State Medicaid Directors

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850
Center for Medicaid and State Operations

SMDL # 04-005

August 17, 2004

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) has supported states in the implementation of the principles of money follows the person (MFP) by providing resources and technical assistance. We are committed to continuing to assist states in implementing the principles of MFP under existing authorities.

A number of states have pursued strategies under existing authority that can be useful models to states interested in making immediate changes to their delivery systems. Previously, we highlighted MFP in two State Medicaid Director letters on August 13, 2002, and September 17, 2003, and provided technical assistance to states through the dissemination of "promising practices" on our Web site. In particular, we have highlighted innovative states including Arizona, Colorado, Indiana, Texas, Florida, New Jersey, Oregon, Utah, Vermont, Washington, and Wisconsin. Still other innovations are occurring under current law with the support of Real Choice Systems Change Grants for Community Living (Attachment #1).

As you know, the term "Money Follows the Person" refers to a system of flexible financing for long-term services and supports that enables available funds to move with the individual to the most appropriate and preferred setting as the individual's needs and preferences change. It is a market-based approach that gives individuals more choice over the location and type of services they receive. A system in which money follows the person is also one that can incorporate the philosophy of self-direction and individual control in state policies and programs.

We are committed to continuing to assist states in implementing the principles of MFP under existing authorities and hope to address areas of confusion that may be impeding efforts to rebalance long-term support systems. This letter intends to clarify a few issues that have been brought to our attention.

Issues Identified to Date

Home and Community-based Services (HCBS) Waiver Capacity and Cost Neutrality:

Although states may implement MFP strategies without a waiver context, states that anticipate using HCBS waivers as part of their rebalancing strategy may be concerned about waiver capacity and demonstrating the cost neutrality of proposed waiver services. States may request to amend their current HCBS waiver program to include additional participants. States that do so are still required to demonstrate the continued cost-neutrality of those programs; however, most states have found that in the aggregate waiver programs continue to demonstrate cost

neutrality even with the addition of waiver participants. Any state that has concerns in this area is asked to work with CMS to assess the underlying assumptions and structural issues of its cost neutrality estimates.

Backfilling of Nursing Home Beds:

States that implement MFP strategies will begin to achieve a more equitable balance between the proportion of total Medicaid long-term support expenditures used for institutional forms of service and the proportion of combined funds used for home health and personal care services under the state plan and waiver services. We anticipate that as individuals have greater choices in service delivery, a smaller proportion of individuals will choose institutional care. We encourage states to reduce nursing facility beds to assist a state in rebalancing its long-term care service system, but this is not a requirement.

Self-Directed Models:

Over the past several years, individuals and families have advocated for directly involving persons who receive Medicaid funded services and supports in the decisions that affect their lives, and providing those individuals with greater choices and control of their services and supports. For individuals to naturally select community services over institutional services, states must ensure that a broad array of quality services are provided under a long-term care system that recognizes service delivery options that are diverse and flexible. CMS is committed to supporting and further implementing models such as those contained in the Cash and Counseling Demonstration and Evaluation Project and the Independence Plus initiative. These programs not only realize MFP principles but use an individual budget to provide participants direct opportunities to make personalized decisions about the allocation of available resources. While CMS continues to encourage states to consider these system reforms, we also recognize other strategies for the provision of HCBS that expand the level of individual choice and control without making major modifications to state infrastructures. Quality community programs offer not just one model of delivering community services but rather a continuum of options in order to allow individuals to select the service delivery method that best meets their preferences, desires, and personal outcomes. The selection as to which option is best may vary depending on the level of other community supports available, or simply the inclination of the individual. Along this continuum, CMS has identified the following four basic service delivery models related to services and supports of personal attendant:

1. Traditional Model
2. Traditional Model Supporting Choice
3. Agency with Choice Model
4. Fiscal/Employer Agent

A description of these models and examples of state innovation is included in Attachment #2.

We will continue to help provide opportunities for people to live in the communities of their choice. We welcome your input and hope you find this information useful.

Sincerely,

/s/

Dennis G. Smith
Director

Enclosures

cc:

CMS Regional Administrators
CMS Associate Regional Administrators
for Medicaid and State Operations
Kathryn Kotula
Director, Health Policy Unit
American Public Human Services Association
Joy Wilson
Director, Health Committee
National Conference of State Legislatures
Matt Salo
Director of Health Legislation
National Governors Association
Brent Ewig
Senior Director, Access Policy
Association of State and Territorial Health Officials
Jim Frogue
Director, Health and Human Services Task Force
American Legislative Exchange Council
Trudi Matthews
Senior Health Policy Analyst
Council of State Governments

Attachment #1

Examples of State Innovation

Under the Real Choice Systems Change Grants for Community Living:

Money Follows the Person Rebalancing Initiative

California

The California Department of Health Services (DHS) is developing models and systems that enable money to follow the person from institutional to home and community-based settings. Specifically, it is developing standardized protocols and processes, including a consumer-focused quality assurance model, a standardized consumer-oriented nursing facility transition care planning model, and a uniform assessment tool and protocol. A pilot project will test the developed tools and protocols, and inform statewide policy decisions about a Money Follows the Person Initiative in California using individual and aggregate data and fiscal analysis based on case examples.

Maine

The Maine Department of Behavioral and Developmental Services is adopting a standardized assessment and budgeting process for mental retardation waiver services that results in consistent, predictable, and truly portable budgets. The State is directing resources toward more person-centered, consumer-driven services offered in the most integrated and appropriate setting and identifying cross-system performance measures that enable Maine to comprehensively and coherently assess its success at achieving a balance of services across systems. Maine is piloting an individual budget tool and assessing its impact on consumer satisfaction, providers, budget neutrality, staffing requirements, and Medicaid management information systems.

Nevada

The Nevada Department of Human Resources is rebalancing the State's long-term services programs so that community services and supports are the primary source of support for people with disabilities. It is identifying individuals for community integration, implementing their transitions, and using peer advocates to assist in the transition process. In addition, Nevada is establishing a Housing Specialist at the Nevada Developmental Disabilities Council to help individuals locate affordable housing and access State and local housing assistance programs. The State is also revitalizing the Nevada Home of Your Own program, an initiative to help people with disabilities secure housing, and developing and maintaining a registry of affordable, accessible housing in Nevada.

Additional examples can be found on the CMS Web site at www.cms.gov/newfreedom.

Attachment # 2

Service Delivery Models for Attendant Care

Service delivery models have been evolving over the last decade and continue to be refined and clarified. The following are four basic models that CMS has identified based on state experiences. Each of these design approaches can be used by states to enable them to employ money follows the person principles. States are not limited in the various strategies they may employ.

Traditional Agency Model

Under a traditional agency model, an agency assumes responsibility for recruiting, hiring, managing, training, and dismissing employees who are hired to provide, at a minimum, basic assistance with activities of daily living to individuals living in the community. The agency sets the wages and hours, and directs the actions of the employee while in the participant's home and provides necessary back-up as needed. Services are provided based on a standardized assessment of needs typically performed by a medical professional. A Medicaid agreement executed with the Medicaid agency, and the provider agency, clearly articulates the scope of the services and identifies allowable tasks that may be performed. The agency is paid by the Medicaid agency to provide personal assistance services.

Traditional Model Supporting Choice

Many traditional provider agencies honor the principles of choice, control, and the person-centered planning process. These progressive agencies allow, or even encourage, participants to identify and refer to the agency, attendants they have selected and offer training in the philosophy of self-direction. Many agencies also provide a list of potential attendants that participants may interview. Back-up is provided by the agency. Attendants are expected to respect participant preferences. States implementing this model may do so without modifying their state plan or waiver services since the provider agency continues to operate under a traditional Medicaid Provider Agreement to provide personal assistance services and is reimbursed for providing these services. The agency continues as the responsible entity over the provision of personal assistance services and over the attendants who provide this service. While the participant has the ability to select his or her attendant, the agency continues its role as the employer of the attendant and retains responsibility for the oversight of the personal attendant service. The Trinity Respite Care in Lawrence, Kansas is an example of a Medicaid provider agency that gives its clients the opportunity to select their own attendants.

Agency with Choice

This model, first described in a research document entitled Consumer-Directed Personal Assistance Services: Key Operational Issues for State CD-PAS Programs Using Intermediary Service Organizations (1997) by Susan Flanagan and Pamela Green, provides an increased level of responsibility by designating the participant as the managing employer without becoming the common law employer (employer of record) of his or her attendant. For IRS purposes and other employment considerations, including making payment to the provider, the agency is the common law employer. The participant recruits, interviews, and selects the attendant care provider and refers him or her to an agency for the completion of payroll responsibilities. An individual budget may or may not be used to determine the available resource allocation. The

participant generally establishes the wages and sets the working hours. Once hired, the participant manages the attendant including the approval of timesheets. The participant may elect to train the individual or may direct the agency to provide training on his or her behalf. The agency may offer additional services to support the participants' ability to self-direct. These supports may include making other purchases (included in the individualized budget) on behalf of the participant, assisting with managing the individual budget or providing training on how to hire and manager attendants. While the agency and the participant share employer responsibilities, the agency executes a Medicaid Provider Agreement with the Medicaid agency to provide the personal care services and any supportive services. The agency may offer a traditional service model along with Agency with Choice services model, but clearly there is a formal distinction between the two models. The New Hampshire Independence Plus initiative, In-Home Supports Wavier for Children with Developmental Disabilities, adopts the Agency with Choice model.

Fiscal/Employer Agent Model:

The Fiscal/Employer Agent model provides Medicaid program participants with the greatest level of flexibility and empowerment. In this model, the participant or participant's designated representative is recognized as the common-law employer of his or her individually hired attendant(s). However, the representative generally delegates the employer-related responsibilities related to payrolling and filing of employer-related payroll taxes to an organization that serves as the program participant's "employer agent." The agency may offer a broad host of services that support the participant as he or she experiences self-direction, including skills training, brokering other benefits such as Workers Compensation or health insurance, or other support functions including assistance with managing the individual budget. The agency may be reimbursed for financial management services as a waiver service or as an administrative function. Many states, including all but one of the "Cash and Counseling" and "Independence Plus" waiver states (Arkansas, Florida, New Jersey, Louisiana, North Carolina, and South Carolina), use this model to allow Medicaid program participants and their families to self-direct.

Appendix C
State Examples

State Experiences

A framework was developed to organize key information under three main components: systems operations, consumer enrollment, and provider recruitment and retention (see ***Table C-1*** below).

Table C-1. State Components

Systems Operations	Consumer Enrollment	Provider Recruitment and Retention
Administrative Structure	Level of Care Eligibility	Provider Eligibility
Intergovernmental Agreements	Financial Eligibility	Provider Enrollment Processes
Communication Strategies	Eligibility Redetermination	Requirements Across Provider Types
Level of Automation	Enrollment Standards	Billing and PAYMENT Standards
Required Resources	Communication with Consumers and Families	Communication with Providers

The following describes key findings from Lewin study of these states.

1. Colorado

Highlights of Colorado's best practices include:

- Implementation of a single entry point (SEP) system for client enrollment, through an RFP process;
- Level of care and financial eligibility responsibilities are split between entities, but staff work closely together through well defined procedures and timelines;
- SEPs are paid on a capitated basis;
- Fast track eligibility system;
- Plan of care is finalized after the financial eligibility determination;
- Fiscal agent assists providers during application process; and
- Providers directly bill fiscal agent.

a. Background

Colorado currently operates 11 Medicaid waivers; the A&D waiver, HCBS-EBD, is one of the state's six 1915(c) waivers and has approximately 15,000 enrollees. Two priorities were outlined in Colorado's recent history of system reform efforts, 1) to develop a new consumer assessment instrument to cross all populations; and 2) to implement a single point of entry system. Legislation authorizing the creation of an SEP was passed in 1991. The state phased-in the implementation of the SEP, beginning with five in 1993, one in 1994, and the rest in 1995.

Colorado's SEP is a locally-administered, state-supervised system based on contracts with each SEP agency and county government. The SEP requirements were formalized in state rules and

the state issued an RFP. County commissioners recommended the agencies and the State contracted only with qualified agencies. The State contracted with 26 local level SEP agencies in districts across the state, comprising a total of 160 local FTE staff. The SEP agencies include: 10 county departments of human services; 10 private, not-for-profit agencies (e.g., stand-alone case management agencies); five county nursing services (public health) operating in rural areas; and one Area Agency on Aging (AAA). There are 10 State Department FTE staff, located in the state Medicaid agency (out of 170 Medicaid staff), who are responsible for overseeing the waiver, monitoring the activities of the SEP agencies, and providing training to the SEP agencies.

The districts did not receive start-up funds, but they did receive some funding for regional implementation and technological support. Each SEP received approximately $1,000 for a new computer and $3,000 per year was allocated to multiple county districts to account for economies of scale issues (i.e., supporting the SEP in rural areas). The districts also leveraged resources from the existing state-funded Home Care Allowance program in which county assessments previously funded by block grant and county dollars became a Medicaid administrative service eligible for federal matching funds. Once districts converted to SEP, they increased available resources by about 25 percent with use of the matching funds. Many of the SEP agencies rolled-over existing clients so they started accounting for consumer enrollments immediately. Dedicated state staff were involved with initial and ongoing training with the SEP staff. There were also some reportedly minimal additional resources for the peer review organizations (PROs) to move to an automated system.

b. Consumer Enrollment

In Colorado, consumers apply for LTC support through the local SEP agency. The SEP agency administers an initial phone screen and if the applicant is in need of LTC services, the SEP refers the applicant to contact the county department of human services to have them mail financial eligibility forms to the applicant. In the meantime, the SEP agency case manager conducts an in-home level of care (LOC) assessment. The SEP is required to complete the LOC assessment within two days if the applicant is in an institutional setting, and within five days if residing in the community—a performance measure that is audited by the state. The state contact reported that the SEPs usually complete the assessment sooner than the time requirement. The SEP uses a tracking system which starts monitoring consumers when they request an assessment. After the assessment is complete, the case manager enters the data in an automated system. The case manager then sends the assessment to a PRO who reviews the information within 24 hours. According to the state contact, the state feels that the PROs are a "rubber stamp" and may eliminate this step and transfer the authority to the SEP agencies.

After determining level of care eligibility, the PRO faxes the decision back to the case manager and contacts the county department of human services for them to begin the financial eligibility process.[70] The financial eligibility assessment is required to be completed within 45 days; the state contact reported that the average is 44 days and believed the timing could be shortened if the county departments were staffed adequately. After reviewing the financial information, the county department notifies the SEP case manager of the client's eligibility determination.

[70] The county department performs financial eligibility determinations for all Medicaid services.

Although there is no tracking system in place for the financial eligibility process, the SEP case managers have strong working relationships with the county department staff and can call them to inquire about an applicant's status. The case manager then notifies the applicant of the eligibility decision, and if the applicant is deemed financially-eligible the case manager conducts a personal visit to finalize a plan of care.

In an effort to address the financial eligibility delay, over the past two years the State has implemented a "fast track" eligibility system. The goal of "fast track" is to prioritize hospital patients who are likely to qualify for Medicaid and are in need of LTC community support, and assess them prior to their discharge (within three days). The state contact estimated that approximately 100 persons are fast-tracked per year. The department of social services in Denver even has financial eligibility workers stationed at local hospitals.

Consumers can choose to keep the same case manager who performed the initial assessment once enrolled in the program. Case managers are required to make a home visit every quarter and call monthly. Case managers use a standardized checklist guide at their appointments. Reassessments are performed annually or more frequently if a client's condition changes. The financial eligibility system also includes ticklers that prompt workers, but this is separate from the level of care reassessment.

The SEP agencies are funded on a per capita per month payment (approximately $785 per year per person) based on the number of community-based LTC clients they are serving. The average caseload of a SEP case manager is 56-58 clients. The SEP agency is not paid for an assessment when a consumer who is assessed goes to a nursing home; they are *only* paid if the consumer goes on to receive home and community-based care. This creates a strong incentive to deter consumers from, or to move residents out of, nursing homes. SEPs have been required to administer consumer surveys to a sample of clients since 1993.[71] The county departments receive Medicaid matching funds for Medicaid eligibility based on FTEs and the state funds are allocated based on the consumer population served.

The state contact reported that there is open communication among the SEP agency, county department, and state staff. SEP agency and county department staff used to meet more frequently, but now meet as-needed. The state has always held joint trainings for the level of care and financial eligibility workers; the joint meetings were held every two to three months when the SEP was implemented, but now are held annually. Administrative meetings between SEP agency and county department administrators are held monthly.

c. Provider Recruitment and Retention

Providers can apply to the system through multiple entry points. SEP agencies are not paid to recruit providers but, by rule and contract, are required to identify service gaps in their area. The SEP agencies can call around for interested providers and send them an application to be certified as a Medicaid provider. SEP agencies receive state recognition at the end of the year for provider recruitment. Generally, a MMIS fiscal agent assists providers with the application

[71] The state requires the SEP sample; 10% of clients or 10 clients for smaller agencies.

process and sends them information packets. If State staff receive questions from providers, they try to answer them and can refer the provider to the fiscal agent.

The certification step is different for different providers, but most providers are certified through the Department of Health. Home health agencies, for example, contact the Department of Health, who then sends a form to a fiscal agent to assist providers during the process and obtain a Medicaid number from MMIS. Durable medical equipment (DME) suppliers contact the State department to request an application to be a Medicaid provider. SEPs certify adult care facilities (assisted living) and perform annual on-site certification of these facilities, while the Department of Health assesses board and care homes. There is also flexibility in the system so that if a SEP agency wants to arrange ramp construction for a client, the case manager can call around and enroll them as a Medicaid provider agency. The State requires individual, personal care providers to be affiliated with an agency. It is reportedly fairly simple for informal personal care workers (e.g., neighbors) to join an agency, except in more rural areas of the state. Criminal background checks are not performed for providers unless they are applying for the state's consumer-directed program.

Provider rates are set at the state level, mostly through the legislature. The legislature sets the total budget amount, the rate per unit, and the number of people to be served. The State contact reported that this was an advantage for the department because it does not get blamed for low rates and it eliminates any potential conflict-of-interest for enrollment agencies. Providers generally remain in the waiver programs even though they complain to the legislature that their pay rates are too low.

When the SEP case manager completes a plan of care, the plan becomes a prior authorization request and is sent to the fiscal agent.[72] The provider bills directly to the fiscal agent, which is usually done electronically by the larger providers. Providers are reimbursed through checks paid on behalf of the State, typically within 7 days of bill submission. The fiscal agent is responsible for tracking claims processing and also handles any provider complaints or appeals. Colorado does not have presumptive eligibility; for prospective clients who are not yet Medicaid-eligible, if the client becomes eligible, providers can be paid up to 90 days retrospectively. The state contact noted that many home health agencies are not willing to take the financial risk. Except for home health agencies, there is no sponsored training on billing procedures for most providers.

2. Washington

Highlights of Washington's best practices include:

- Implementation of SEP with State employees at local offices;
- Co-location of level of care and financial eligibility workers fosters teamwork;
- High level of automation for level of care eligibility and service authorizations;
- Case management and redetermination in residential settings performed by State employees, in-home case management and redetermination performed by AAA staff;

[72] Colorado used to contract with EDS, but now uses ACS as their fiscal agent.

- Automated record of financial eligibility for all programs; and
- Mandatory provider training.

a. Background

Washington is a national leader in innovative home and community-based delivery systems. The Community Options Program Entry System (COPES) is the Medicaid waiver serving approximately 30,000 home and community-based A&D persons. There is administrative consolidation of aging and disability services at the state and local level, which has promoted administrative and policy coordination throughout the system. The Aging and Adult Services Administration (AASA), within the Department of Social and Health Services (DSHS is the single state Medicaid agency), has broad administrative and policy responsibility of all Medicaid and non-Medicaid LTC programs.

The AASA conducts annual monitoring of AAAs for administrative and fiscal requirements, develops standardized client assessment tools, conducts the initial assessments and service authorization, runs a mandatory training program for providers, sets the requirements for a criminal background check, establishes case manager contact standards, operates a system for complaints and investigations, and establishes program standards for AAAs and their subcontractors.

A SEP system was implemented at the local level for all publicly-financed services. The full system was implemented in less than three years and, reportedly, could have been implemented much sooner if they did not have the degree of political considerations (i.e., deciding to make that entry point with state staff level only and converting work assignments). State employees at the local DSHS offices perform level of care and financial eligibility and provide case management for individuals in nursing facilities and nonmedical residential facilities (i.e., adult family homes, adult residential care, and assisted living).[73] AAAs provide ongoing case management and reauthorization of in-home services. The State contacts reported that the relationships between the State and the AAAs were very good. The AAAs pay vendors for their services and are then reimbursed by the state Medicaid agency. Independent providers are paid directly by the State.

Since Washington already had an assessment tool and the necessary staff in place, the SEP implementation activities mostly involved transferring cases to the aging network for ongoing case management and using existing resources for developing and publishing program brochures. Their major investment has been in a tool to automate their system for level of care determination and service authorization. The redesign of their assessment instrument into an multifunctional, automated tool has taken nearly five years and cost approximately $3 million in total funding.

b. Consumer Enrollment

Consumers in need of LTC support contact the local DSHS office (SEP) to be assessed for publicly-financed programs. Level of care assessments are administered by local nurses, social

[73] Washington has a very high supply of community-based residential facilities compared to other states.

workers and case managers of the SEP office and are required to be completed in-home within seven days. The level of care assessment is heavily technologically based. Case workers use a software program on their laptops that guides the case worker through the assessment, which is uploaded to the mainframe. It has the capability to determine level of care and make real-time automated computations for service authorizations. According to a recently completed workload study, the total level of care assessment takes 5.5 hours to complete. The level of care assessment and care plan must be completed within 30 days. The state contacts reported that the timeline is usually adhered to, although the providers might not be lined up within that time.

The software can produce a care plan and future upgrades will allow for an applicant's electronic signature on the plan during the same visit. If the client already has chosen a provider and knows what informal supports are available, data could be immediately entered. After the care plan is entered, the client and case worker are able to know how many hours of service the client is eligible for, who the providers will be, the days and frequency of service, etc. This will also be linked to a provider database, in which clients could search and select providers based on their own criteria, to be included in a service plan.

At the time the local DSHS office (SEP) conducts an initial intake, the worker can verify if the consumer's information is already in the financial eligibility system. If the consumer is not registered in the system, a financial eligibility worker at the same local office is notified to begin the financial eligibility process.

The social worker performing the level of care assessment often assists the financial worker in collecting the necessary financial information. Otherwise, financial information is gathered by mail; Washington is trying to move to using more electronic methods for this piece. Financial eligibility determination must be completed within 45 days from the time the financial worker gets notification that the consumer would like to apply, occasionally starting with a name and address only. The state contacts reported that the large majority of financial determinations are completed within the 45 day requirement. They noted that an entire culture has developed around meeting the timeline and it has become a staff performance measurement. Financial eligibility workers are pressed to be aggressive in gathering the necessary information. The local offices monitor the process and supervisors receive reports of those determinations taking longer than the established timeframe, which financial workers must be able to explain. There is an internal standard to complete the determination in 15 days. Once an applicant's financial information is gathered and entered into the system, the technology used by the local SEPs generates automated records of all public programs for which the client is eligible (Medicaid waiver program, personal care, food stamps, and others).

Both level of care and financial redeterminations are required annually. Level of care assessments must also be completed if there is a change in status. Reportedly, the current assessment does not build in assurances that all needs are addressed. The state will be launching a new assessment tool in the near future in which, at the time of reassessment, the case manager would note changes in a client's status and also verify those elements in the previous assessment that have not changed. AAAs have a caseload goal of 85 clients per case manager. The 1:85 caseload equates to a visit within 30 days of assignment, a minimum of two phone contacts, a six-month visit, and an annual visit. In reality, the average caseload is closer

to 95 clients although sometimes it falls below 85. The AAAs are required to submit an FTE staffing plan with their annual renewal contracts.

c. Provider Recruitment and Retention

The Washington Department of Health initially licenses all in-home agency providers. Over the past few years, the state has worked to streamline this process and reduce the paperwork. Residential Care Services, within the AASA, centrally manages the licensing and complaint investigation of boarding homes (comprising adult residential care homes and assisted living facilities). Provider information is immediately entered into the computer system (SPSS). Within the DSHS, there is a centralized background unit to check provider criminal records. All LTC providers, including independent providers, must submit to a criminal background check. The local SEPs contract with enrolled providers and the case managers are responsible for ensuring that once providers have passed background checks, they complete a state-required training program. The training program varies depending on type of provider and experience.

The AAAs are required by contract to set standards for providers regarding: billing procedures, time sheets for all agency workers and independent providers, and performance evaluations for all agency workers. In contrast, most of the requirements for independent providers pertain to when they are initially hired and there is far less oversight and accountability controls than with agency providers. The AAAs monitor service providers and send the results to the Department of Health. The State is moving away from emphasizing administrative requirements for quality assurance and toward implementing more performance and program results monitoring.

When the State SPSS system receives an invoice from a provider, it generates an invoice for the next payment cycle that providers verify via touch-tone phone on a monthly basis. The case managers also verify provider hours and type of service with their clients. Case managers sample a percentage of time sheets to make sure the timesheets match the services provided. Providers are currently issued monthly checks and the state contacts reported that providers seem satisfied with the system. However, independent providers have requested checks to be issued twice per month, which the SPSS system cannot accommodate. The state does not want to move to another system because SPSS is timely and other systems, such as MMIS, lack the capability of handling the tax functions required to pay independent providers. The state has set up a toll-free number for providers to call regarding payment issues, although some calls do go to the state DSHS office or case managers.

The DSHS generally sets provider rates, but sometimes the legislature makes the decision. The DSHS and other stakeholders have spent the last five years researching ways to improve the community rate system (especially for residential care providers). Adult family homes, adult residential care, and assisted living facilities are reimbursed according to geography and level of disability. The A&D waiver offers the same hourly rate for home care services as other waivers.

Though the individuals on COPES can receive services up to the cost of 90 percent of the going rate of nursing home care, the state contact reported that the state budgets about 40 percent of nursing home costs. In fiscal year 2000, the average monthly cost of COPES enrollees was $959. Over 55 percent of COPES clients use independent providers rather than agencies. State regulations require that clients who need more than 112 hours of service per month must use an

independent provider.[74] The prior emphasis has been to remain in budget through the limitation of hours, but the new emphasis is to control costs by allocating more services to those who are in need of more services and fewer services to those who need less.

The State is initiating several projects to respond to workforce shortage problems. Washington allows nurse delegation, which reduces the need of higher-paid skilled nursing staff. The state is hoping to expand the practice of nurse delegation. They were a recipient of a CMS Real Choice Systems Grant for caregiver recruitment and retention. In addition, they have established two pilot projects that focus on recruitment and retention at the local level. This has included the development of a provider registry of "willing and ready-to-go workers" and the establishment of training programs pertaining to consumer supervision.

3. Wisconsin

Highlights of Wisconsin's best practices include:

- Under the Family Care system, Memoranda of Understanding were developed at the state and local levels and contracts with specific obligations were developed;
- Authority delegated to the local level to make eligibility determinations and authorizations;
- Merged assessment and level of care;
- Network Developer established as single contact for providers in each county; and
- Consumer-defined quality of care performance measurement system.

a. Background

Wisconsin has always relied on a strong county-based system for the administration of home and community-based LTC in which the bulk of services are delivered through contracts with community providers. The State contacts reported that approximately 18,000 individuals are served in all waiver programs, with 9,000 on waiting lists maintained by the county.[75] There are approximately 6,800 enrollees in the State's pilot program, Family Care—an initiative that began in 1998 in response to growing problems of access, cost and quality of LTC. Family Care is a new capitated LTC system being piloted in several counties. The Family Care model uses Resource Centers on the front end, designed to create "one-stop shopping" (SEP) for information and assistance for the elderly, physically, and developmentally disabled.

Of the nine county Resource Centers currently operating, seven were piloted in year 1, one in year 2, and one in year 3. In 2002, the nine Resource Centers had a total of 140.56 FTEs (a 22 percent increase from 2001). The number of functional screens completed per FTE during January to March 2002 ranged from eight to 52 screens. County Resource Centers received an annual budget from the Wisconsin Department of Health and Family Services (DHFS) in the form of prepayments equal to one-twelfth of the grant amount for each of the first three months

[74] It was noted that the administrative costs associated with the use of independent providers are borne by the AAAs.

[75] The developmentally disabled and the physically disabled populations comprise the largest and longest part of the waiting lists.

of the contract. Future monthly payments made by the DHFS were based on expense reports submitted by the Resource Center. Total start-up funding from calendar year 1998 through 2000 amounted to nearly $3 million in addition to $5.5 million in reallocated funds for Resource Center contracts. In 2000, total spending for all Resource Centers was $4.6 million (ranging from $101,452 to $1.5 million each).

The full model of Family Care also includes the use of a Care Management Organizations to plan care, coordinate, and manage an array of LTC services. Across counties in 2002, caseloads ranged from 30 to 50 consumers per social worker for elderly and physically disabled consumers and from 30 to 45 for developmentally disabled consumers. Caseloads of registered nurses ranged from 50 to 125 per RN. Start-up funds for the five Care Management Organizations from calendar year 1998 through 2000 amounted to approximately $6.4 million; total Care Management Organization spending was nearly $32 million in 2000. The State provided funds within the counties' start-up grants for information technology development. Spending on information technology represented 32 percent of all Family Care start-up funds.

Resource Centers and Care Management Organizations are overseen by the DHFS. Family Care operates under a 1915 b/c combination waiver. Economic Support Units are county entities under the Wisconsin Department for Workforce Development that are responsible for determining financial eligibility across different low-income populations for the regular waiver and Family Care programs. Economic Support workers are employees of different county organizations (e.g., human service departments). The State reported that they feel they have less control of Economic Support workers because they are from a different state unit. There has historically been tension between the State and counties. Regional staff meetings are held with regional and state level staff to discuss policy and program issues, but problem-solving is not much of a priority at these meetings. Under Family Care, memoranda of understanding were developed at the state level between different departments and among partners at the local level by requiring Resource Centers to develop an "access plan" of how the various local partners would coordinate service delivery. Contracts for Resource Centers and for Care Management Organizations were developed by the State to specify obligations and accountability, replacing the vague language of the waiver manual.

b. Consumer Enrollment

In Wisconsin, consumers know that the application process for LTC begins with counties. Under the older system, the county agency processed level of care eligibility using manual screening tools. They sent the paperwork to a contracted agency for review and to process the assessment and plan of care. Notice of level of care eligibility was then sent to the Economic Support Unit, which handled financial eligibility for all public programs for low-income populations. The review and final approval process by the state took longer than anticipated.

Under Family Care, both level of care and financial eligibility is processed at the county level. Level of care eligibility determination is conducted by the Resource Centers using an automated, Web-based functional screen tool to handle level of care eligibility determinations. CMS considers the screen to be the initial assessment from which one can develop an initial plan of care and put services in place. The automated screen is now being used outside the

Family Care pilot sites.[76] The automated functional screen has built-in logarithms that produce level of care determinations and can discern which nursing home level, developmentally disabled level, and if the individual is waiver-eligible or eligible for the State Community Options Program (COP). Some information on the functional screen needs to be verified by a physician, but the screen does not need a physician sign-off.

The functional screen is sent to the State and communicated to the Economic Support Unit. The Economic Support workers have access to the State database. Once the Economic Support worker receives level of care eligibility notification, the worker contacts the consumer to collect more documents to process the financial eligibility. In the old system, the Economic Support workers handled financial eligibility for mixed low-income populations. While waiver recipients, as a proportion of measured Economic Support worker functions, generally constitute a small percentage of total worker caseloads, the proportion of the caseload accounted for by waiver enrollments nearly tripled in some of the counties since the start of the Care Management Organizations. Under Family Care, Economic Support workers have begun to specialize in waiver and nursing home eligibility determinations.

Prior to Family Care, the entire eligibility process took about 2.5 months. Under Family Care, the new screen has shortened the front end substantially and level of care eligibility can be processed in about one week, because it bypasses state approval. The state implemented a certification requirement for those using the new screen. The screeners take a Web-based training course consisting of a series of 10 tests. The state feels that with the use of the new screen, eligibility cannot be "stretched" as much as under the old system. There is a new prescription drug program in Wisconsin and it is the hope of the state that this will prevent stretching the functional screen to fit the need for drugs.

According to program requirements, everyone meeting the "comprehensive" level of care eligibility is assured of receiving services in a timely manner. Everyone who meets the "intermediate" (lower) level of care eligibility and who is Medicaid-eligible or has a confirmed need for adult protective services also is assured prompt access to Family Care services. Others at the intermediate level not meeting the above state criteria are eligible for services, but may be placed on a waiting list if funding is not immediately available.

If a consumer is approved for Family Care, he/she must meet with an enrollment counselor to receive "choice counseling" prior to enrolling in the program with a Care Management Organizations. For waiver approvals, CMS was concerned about the potential for conflict of interest if a single entity (the county) was responsible for all aspects of eligibility determination and enrollment—creating an opportunity to restrict care or limit eligibility. CMS approved the DHFS' solution to use an independent enrollment broker to provide consumers with unbiased information about available program services.

Tracking the application process is done through an on-line system. There is a lag of a few days in the system, but it starts a 30-day eligibility clock. A notice is generated for consumers if the process is being delayed for some reason. The case worker from the Resource Center

[76] The state contacts reported that 20 of Wisconsin's 72 counties currently use the Web-based screen and expect that it will be adopted by many more counties next year.

communicates with the applicant throughout the process. The State contacts reported that consumers get a notice in the mail that is generated by the computer system and can be confusing for the applicant. As a result, the Resource Center case worker often has to explain the notice and many case workers call before the notice is generated to avoid confusion. Applicants who receive denial notices receive appeal instructions on those same notices.

The eligibility database system automatically generates notices to Economic Support workers of those clients in need of financial recertification on a 12-month cycle. Care managers are responsible for developing annual care plans and perform the level of care reassessments, as needed. The use of the new functional screen requires annual updates, which the care managers perform. Methods of notification to care managers of reassessments differ across counties. Some counties have automated systems to notify care managers, others have care managers track it themselves.

Under the older system, counties received payments for front-end functions: $110 per screen and $200 per care plan. Family Care uses a capitated model in which Care Management Organizations receive payments per person per month to manage and pay for care for members who live in their own homes, group living situations, or nursing facilities. A large portion of the Care Management Organization's administration is in the form of care management. Under the older system, the State contributes most of the administration dollars; several counties put in county dollars for other administrative costs in the old waiver program and receive a federal match. With Family Care, the State provides administrative funding at 7 percent and the counties devote their dollars for service costs. Most of the funds for Family Care are redirected federal Medicaid match and existing state spending for the old state and Medicaid 1915(c) waiver programs. Counties are also providing gap funding and in-kind support for some administrative functions.

The rate methodology has continued to evolve toward a prospective payment system. The DHFS implemented prospective payments with retrospective adjustments based on historical use cost bands and are moving to a prospective rate based entirely on data from the functional screen. The pilot counties argued that they were not adequately funded by the state and that the Economic Support function is not adequately staffed. Processing financial determinations under Family Care produced a significant strain on the Economic Support workloads which DHFS did not forecast largely due to operating in a separate state division. This created a significant backlog in Milwaukee County. The allocation to Economic Support Units has grown with increased Family Care enrollees.

c. Provider Recruitment and Retention

Under the older system, county agencies recruit and contract with providers and certify adult family homes (1 to 2 residents). The State certifies large housing providers. For personal care providers, the state is responsible for certifying large providers and the county certifies smaller agencies. Counties can certify self-employed providers under State requirements in a memo that details standards that the county has to apply to small providers. Also, a number of counties run their own personal care services because there are not enough providers. Under Family Care, counties are responsible for building a network of providers to offer consumers choice and promote quality. Each CMO funds the position of a "Network Developer" who is responsible for developing the network and acts as the main contact with providers.

The process of becoming a Medicaid provider is relatively fast. Providers can operate under a provisional license during the waiting period, which can be about 45 days for an entity that is already functioning. The State requires criminal background checks for providers. The State maintains a criminal justice registry and a caregiver abuse registry (records substantiated allegations of misuse of funds, treatment, etc. of individual caregivers). Much has been done at the State level to revamp the requirements recently. There are training requirements for residential providers that must be met annually; home health and personal care providers have their own requirements to meet for certification and each county has its own certification process.

Under the older system, waiver rates are similar to Medical Assistance card services, which are set at the state level. Under Family Care, counties negotiate rates with providers. Providers have an opportunity to be paid a higher rate if the organization delivers a higher quality product. Also, rather than receiving 1/12 of the payment up-front at the beginning of the month, Family Care providers bill for the number of units of service provided and then get paid. The county generates checks to the providers and reports to the State when payment has been made. Under the old waiver, the county agency is responsible for ensuring that billing is accurate and matches the services delivered; in Family Care, this is the responsibility of both the care manger and the Network Developer. Furthermore, the annual screen has quality checks in place to prevent ineligible consumers from receiving services. Under Family Care, eligibility cannot be back-dated because payment is not received until the consumer is enrolled.

Quality assurance activities under Family Care have diminished the autonomy that providers had in the old system. Previously, providers would drive the care plan and just sign off on how many hours they worked. Under Family Care, providers only get paid for services delivered, which are verified at the individual level. Oversight of the waiver program is the State's role. In the older waiver, a State contractor tried to visit all the counties at least once every two years. In Family Care, the External Quality Review Organization (EQRO) reviews care plans on a periodic basis. Each initial care plan is reviewed by quality assurance staff at the beginning of service.

Beginning with Family Care, the State developed a Member Outcomes tool in conjunction with consumers and quality assurance experts with experience implementing consumer-defined quality reform in the developmentally disabled field. Individuals are trained to conduct interviews with consumers and their care mangers pertaining to 14 consumer-developed outcomes. The interviews are more conversational than standard surveys to allow for as individualized responses as possible. Two rounds of interviews have taken place with two different samples of Family Care members, and the tool was also administered to samples of other state LTC program participants.